REPORT TO THE JOINT COMMITTEE ON HEALTH CARE OVERSIGHT DEPARTMENT OF HUMAN SERVICES PLAN FOR MANAGED CARE OPTIONS FOR ADULTS WITH DISABILITIES IN MEDICAID

Submitted By:
Ronald Lebel, Esq. Director,
Department of Human Services
State of Rhode Island and Providence Plantations
Louis Pasteur Building
600 New London Avenue
Cranston, RI 02920
(401) 462-2326 Phone

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Executive Summary

In response to the passage of legislation H 5734 and S 0801, the Department of Human Services (DHS) has developed a proposal for voluntary managed care options for adults with disabilities in Medicaid designed to better meet their medical needs, balance the support services between the community based and institutional settings of care, and curb the trend of expenditure growth. DHS offers managed care models that are designed to support different disability populations and that promote the "management of care" rather than traditional HMO "managed care." This approach builds on the philosophy that coordinated access to quality, evidence-based health care and cost containment efforts; need to be flexible, measurable and accountable.

For the management of care approach, DHS is recommending two voluntary managed care solutions: Primary Care Case Management (PCCM) model and a comprehensive health plan model. When compared with all Medicaid populations, adults with disabilities and elderly constitute 25% of beneficiaries and 66% of expenditures. Specifically, within this population, there are approximately 15,210 people who are eligible for Medicaid, but not for Medicare, and who reside in the community. The voluntary managed care program options described in this report are tailored to this group. Proposed are health care delivery models that focus on access and choice, which foster quality and cost-effective care in a community-based setting. Given the growth trends in this segment of the population, it is essential that the health care model promotes increased use of appropriate services, decreased avoidable admissions to institutional settings of care, and be accountable for measuring and monitoring performance outcomes.

With input from stakeholders and experience learned from Rhode Island and other states, the design of these two models should be phased-in to address the complex health care needs of the 15,210 adults with disabilities living in the community. In addition, DHS would offer the health plan option to 150 Children with Special Health Care Needs that are enrolled in RIte Care who would "age out" of the program each year when they reach 21 years of age and to 2,800 adults with disabilities whose families are enrolled in RIte Care.

The management of care approach is aligned with the concept of creating a "medical home" to coordinate preventive and primary care through contracted arrangements with innovative practice models that are consumer-focused, quality-driven and cost efficient. Within this context, the managed care options DHS has proposed for the eligible population of adults with disabilities in Medicaid will offer access to flexible, coordinated models of care that are not available under the current Medicaid Fee-For-Service (FFS) delivery system. The managed care models offer solutions to meet the complex medical, behavioral, ancillary, and dental service needs of the individual by reducing barriers to care, expanding access to providers, offering flexible benefit delivery, and creating opportunities for improved quality of life in the community.

DHS has identified existing practice models in the Rhode Island health care market that should be part of the managed care community practice model network. Participation by the Rhode Island Health Plans in the comprehensive health plan option is anticipated. In addition, DHS would potentially issue a Request for Information (RFI) to solicit additional innovative practice models to serve adults with disabilities from the Rhode Island health care provider community. Information from the RFI may be blended into the procurement documents. Value–based purchasing strategies would include establishing Certification Standards that demonstrate the qualifications of the provider, contractual performance standards tied to reimbursement, monitoring of performance outcomes, and reinvestment of savings into the managed care models.

There is a real opportunity to improve the delivery of care for adults with disabilities in Medicaid and to curb the expenditure growth by shifting avoidable and unnecessary care from the institutional setting to a community based setting. The hospital –based **only** cost for the eligible population of adults with disabilities was $451 per member per month (PMPM) in SFY 2004. While we recognize that adults with disabilities are more medically complex, the costs are displayed to illustrate the PMPM cost associated with the hospital-based setting of care.

DHS is well positioned to implement the managed care options further described in the report. Through value-based purchasing, the funding of programs that weave the appropriate management of care in the community setting will improve the quality of life for the consumers in a cost efficient manner.

Section 1. Introduction

The Department of Human Services (DHS) is pleased to present this report to the Joint Committee on Health Care Oversight outlining the department's proposal for voluntary managed care health options for adults with disabilities in Medicaid, as directed by the passage of H 5734 and S 0801. The Governor's Commission on Disabilities endorsed this legislation in recognition that improvements to the health care delivery system for adults with disabilities would lead to improved access and wellness outcomes through the establishment of a medical home and access to quality health care services in the community. In alignment with the department's philosophy of customer-focused, valued-based purchasing of services that meet the needs of the consumers in the most appropriate setting, the voluntary managed care options were designed with input from persons with various disabilities, personal caregivers, primary care, specialty care and behavioral health providers and administrators, cross-departmental state agencies and Centers for Medicare and Medicaid Services (CMS) regional staff.

This section of the report presents an overview of the legislation, the issues in the current Medicaid health care delivery system, and how DHS has responded.

Section 1.1 Legislation

Enabling Legislation

House Bill 5734/Senate Bill 0801 directed DHS to plan and implement a voluntary managed care health system for adults with disabilities to ensure that individuals with disabilities have access to quality and affordable health care. DHS was authorized to create a proposal that outlines the following areas.

Developing managed care options for Adults with Disabilities

"In order to ensure that individuals with disabilities have access to quality and affordable health care, the department is authorized to plan and to implement a system of health care delivery through a voluntary managed care health system for such individuals. Managed care is defined as a system that:

- Integrates an efficient financing mechanism with quality service delivery;
- Provides a medical home to assure appropriate care and deters unnecessary and inappropriate care; and
- Places an emphasis on preventive and primary care."

Obtain necessary federal authority

"The department is authorized to obtain any approval and/or waivers from the United States Department of Health and Human Services, necessary to implement a voluntary managed health care delivery system to the extent approved by the United States Department of Health and Human Services."

Report to the Joint Committee on Health Care Oversight

"The department shall submit a proposal to the Permanent Joint Committee on Health Care Oversight no later than April 1, 2006 that proposes an implementation plan for this voluntary program, based on beginning enrollment not sooner than July 1, 2006. The report will describe the projected program costs and savings, the outreach strategy to be employed to educate the potentially eligible populations, the enrollment plan, and an implementation schedule."

Section 1.2 Problem Statement

Rhode Island's Medicaid program for adults with disabilities pays for services, as defined in the benefit package, for some of the State's most vulnerable people. The complex medical needs of this population are often accompanied by behavioral health and social service needs that require a high degree of coordination. Within the many Medicaid eligibility pathways, this population often enters the DHS system as a result of an acute episode of care. Expenses for non-elderly adults with disabilities in Medicaid were $557 million in SFY 2004.[1] When compared with all Medicaid populations, adults with disabilities and elderly constitute 25% of beneficiaries and 66% of expenditures. Specifically, within this population, there are approximately 15,210 people who are eligible for Medicaid but not for Medicare and who reside in the community. The voluntary managed care program options described in this report are tailored to this group. Proposed are health care delivery models that focus on access and choice and foster quality and cost-effective care in a community-based setting. Given the growth trends in this segment of the population, it is essential that the health care model promotes increased use of appropriate services, decreased avoidable admissions to institutional settings of care, and be accountable for measuring and monitoring performance outcomes.

An adult with a disability could have been born with a disability or acquired the disability. Each individual has unique needs which impact access to appropriate health care service. Health care needs can range from physical to developmental to cognitive, and, in some cases, a combination including chronic medical illnesses. Some elements of the complexity of the needs of the population and the delivery system itself are addressed below in further detail.

[1] Medicaid Annual Report Fiscal Year 2004

Complexity of the population

Many of the eligible population for the voluntary managed care options are medically complex and frequently without social supports. This culturally diverse and economically disadvantaged group can be overwhelmed with physical, mental health and social issues. Many individuals have multiple chronic medical and behavioral health conditions that present unique challenges for any health care delivery system. Acute episodes or difficulties in accessing needed services can exacerbate an already fragile personal health balance.

Some people within this population lack the skills or the resources to take care of their routine health needs or to recognize when their medical conditions are worsening. They may not know where to turn for help, and often can't find a physician willing to accept their Medicaid coverage. The person often will end up in the Emergency Department (ED) for care that could have been managed in the ambulatory setting.

The range of chronic medical conditions is high in this group. Most individuals have three (3) or more complex medical conditions. Over 30% have significant behavioral health conditions, either as a primary condition or co-occurring with a medical condition. Additionally, obesity is becoming a significant problem, which impacts medical conditions and increases physical limitations. The most common and costly medical and behavioral health conditions occurring in this population, identified through the Medicaid Management Information System (MMIS) and Drug Utilization Review Data, are listed in the table below.

Figure 1.1: Number of unique eligibles within the target population (15,210) who have the following conditions **Total Eligible Population 15,210**	**Number of individuals* with this diagnosis**	
	SFY04	**SFY05**
Common/ Costly Primary Medical Conditions Totals	**11,784**	**12,380**
Hypertension	3532	3744
Diabetes	2575	2650
Chronic Obstructive Lung Disease	2528	2457
Asthma	1482	1452
Coronary Heart Disease	1105	1178
Congestive Heart Failure	500	450
HIV	Unavailable	386
Sickle Cell	26	25
Quadriplegia	25	23
Cystic Fibrosis	11	14
Primary or Co-Occurring Behavioral Health Conditions		
Psychiatric and Substance Abuse Entire Range Totals	**7323**	**7409**
Common Behavioral Health Conditions		
Depression	1351	2621
Major Depression	1972	1881
Schizophrenia	1063	1375
Drug Dependence	1204	1221
Tobacco Use	943	926
Alcohol Dependence	458	456
Post Traumatic Stress Disorder	453	445
Bipolar Disorder	230	202

Source: MMIS and DUR Board Data 2004 and 2005
* Individuals could be in more than one category

Complexity of the existing system

The challenges faced by consumers with their disabilities are further magnified by the intricacies of the maze of often-uncoordinated medical, behavioral, social, dental, and ancillary services. The current Medicaid FFS system is fragmented, with many individuals having multiple providers, multiple sites of care, and no medical home. A coordinated process for assessment of the individual's medical and social needs to be developed. A single point of contact with knowledge of the array of resources available to educate the provider, caregiver, and beneficiary is lacking in the current system. This often results in the utilization of a higher percentage of Medicaid services and expenses for this population. All consumers of medical and behavioral health services can face challenges trying to obtain needed services.

Access Barriers

Finding a provider for medical, behavioral, social, dental and ancillary services that will accept Medicaid reimbursement can be a daunting task. Transportation to medical appointments is not flexible, especially for same day appointments. Access to dental providers is especially difficult. The system of health care delivery for adults with disabilities needs to be redesigned to weave the service delivery of medical and behavioral services and integrate links to dental and ancillary services to meet the individual needs of the consumer. Many adults with disabilities have chronic care management needs that require the integration of the medical and social services that promote wellness and better meet their complex health care needs. Early identification of chronic medical conditions and treatment in a community setting can lead to better health outcomes and avoid unnecessary and costly hospitalizations and nursing home settings of care.

Cost Trends-High Institutional Utilization

This population has high utilization of the Emergency Department (ED), frequently leading to hospitalization. The high concentration of the delivery of services in an acute care environment generally does not include the coordination of the wide spectrum of services needed to treat their complex medical conditions. Behavioral health diagnoses often are co-occurring with the acute medical diagnoses. The Medicaid FFS health care delivery system results in acute episodic care as opposed to primary and preventive care, which promotes wellness and decreases unnecessary, avoidable hospitalization. Curbing the trend from acute costly settings to community-based settings focused on prevention will lead to better health outcomes.

Lack of Accountability for Quality

Lack of coordinated care in the traditional Medicaid FFS model does not promote the balance of accountability and accessibility to quality health care. Oversight and monitoring of quality measures through the integration of evidence-based practice models will lead to improvements in meeting the needs of the consumers. For this population, Medicaid is the payer of services, rather than the purchaser of services tied to specific standards and clinical guidelines.

Increasing Demands

Advances in medicine have extended life expectancy, and the number of adults with disabilities is growing, a trend that is expected to continue. Many of the adults with disabilities within the Medicaid system have no family support at all; in fact many are totally alone. For those with a level of family support, these caregivers are aging and, with time, will be unable to continue in a care-giving role.

Results from the 2000 U.S. Census indicate 25% of families report an adult member with a disability. Demographic trends, such as an increasing divorce rate and more women

working, indicate a growing demand for efficient services and for long-term supports. To a greater and greater degree, more pressure will be place on the public sector for meeting the diverse and complex needs of this population. In fact, this population tends to be multi-systemic, requiring assistance of several state-funded programs.

Budgetary Constraints

The Medicaid health care system, with current enrollment and cost trends, is unsustainable in the environment of budget reductions on both the federal and state level. The cost of health care in the FFS system continues to increase. States across the country are seeking to improve access, quality, and cost efficiency by enrolling adults with disabilities into more focused, highly coordinated health care delivery systems.

In Rhode Island, we know that we can, and must, take action to improve the delivery of health care services to adults with disabilities in Medicaid. Rhode Island taxpayers and the consumers in the Medicaid program cannot afford the cost of inaction.

Solutions and Opportunities for Improvements

The action required to promote and maintain independence in the community for this population will be to implement managed care options for adults with disabilities necessary to improve health outcomes, while slowing the rate of expenditure growth.

The design of the program must address access to quality, customer-focused health care that promotes a "medical home," with an emphasis on measurable preventive and primary care using evidence-based practice guidelines. The concept of a medical home will foster coordination of health care services designed to meet the needs of the individual. Through the creation of the management of care concept, delivery of the health care will be achieved through contractual specifications, with specific quality measures and monitoring for accountability. We are mindful of the need to coordinate the medical home model with the existing system of community supports to assure that the resultant overall system is consumer-centric.

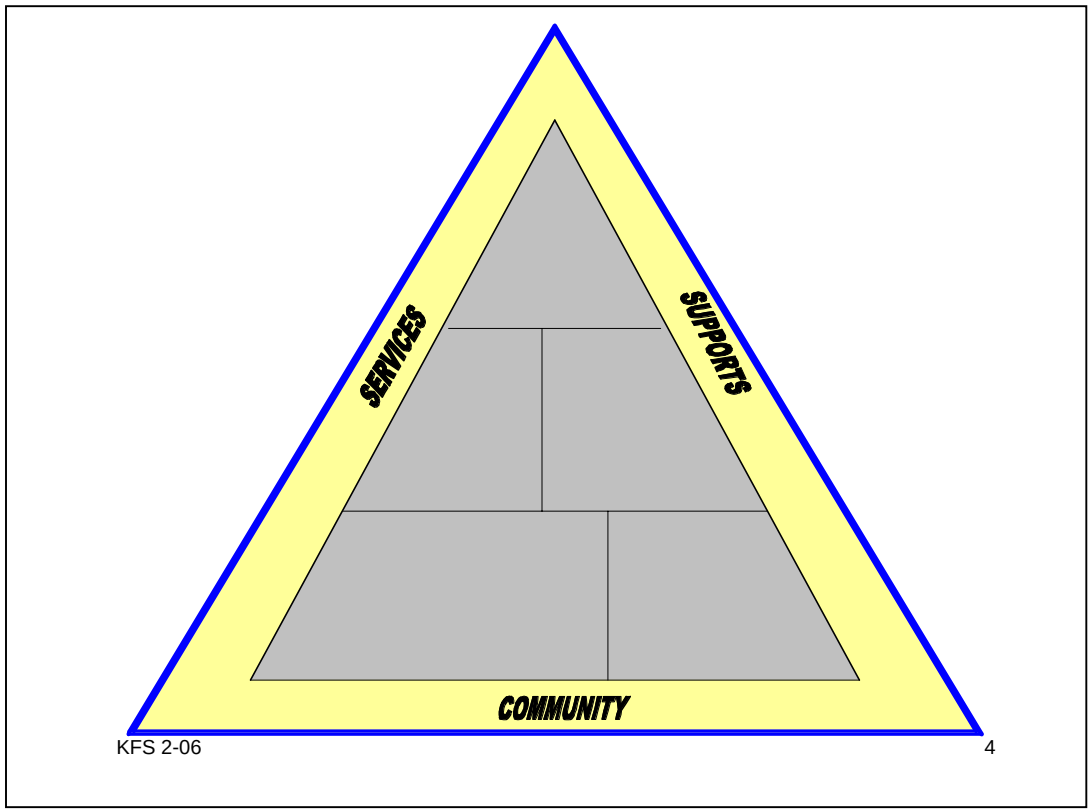
Anticipated Results

The anticipated results for this population will be improved quality of life and continued independence in the community. By reducing the barriers to care, while at the same time shifting the setting of care from acute to a chronic care model, expected reductions in acute episodic care and functional decline will be realized. These enhancements should moderate the trend of expenditure growth for this population. Coordinated, flexible health care services should lead to utilization of appropriate quality health care designed to meet the holistic needs of the individual.

Proposal For The Population

For the "management of care" approach, DHS is proposing two voluntary managed care solutions: a Primary Care Case Management (PCCM) model and a comprehensive health plan model. The design of these two models will address the complex health care needs of the 15,210 adults with disabilities living in the community by providing access to quality, consumer-focused, evidenced-based, cost-efficient health care tied to specific performance outcomes. In addition, DHS would offer the health plan option to 150 Children with Special Health Care Needs (CSHCN) that are enrolled in RIte Care who would "age out" of the program each year when they reach 21 years of age and to 2,800 Adults with disabilities whose families are enrolled in RIte Care.

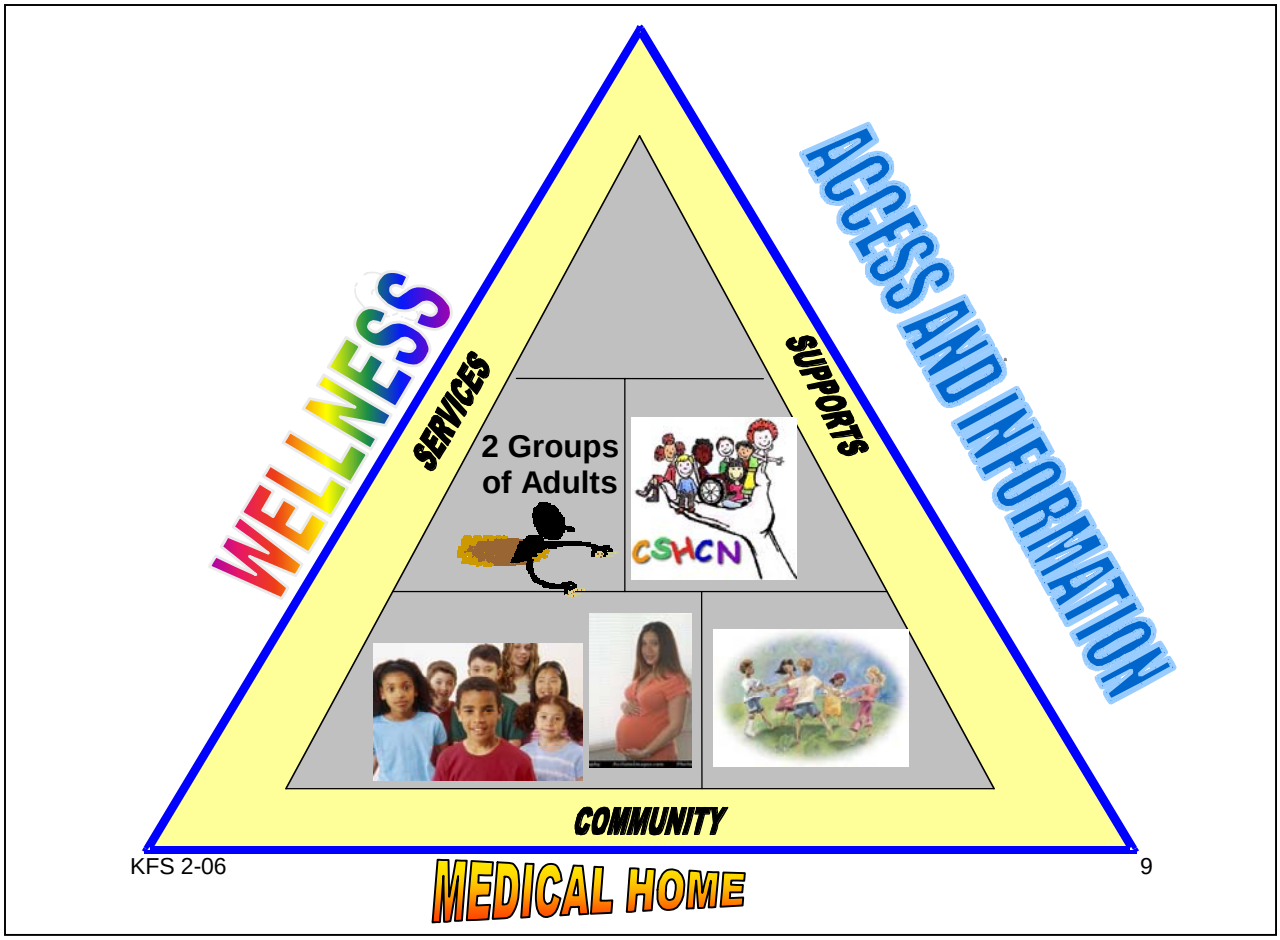
Figure 1.2 Landscape Of Medicaid Before Managed Care[2]



Rhode Island began implementing managed care programs to help people access medical care and stay in the community. In developing the programs, it was recognized that there were many gray areas of unmeet needs and that the needs were not the same for each group.

[2] Prepared by Kathleen Fresher-Samways

Figure 1.3 Landscape Of Medicaid Since Managed Care



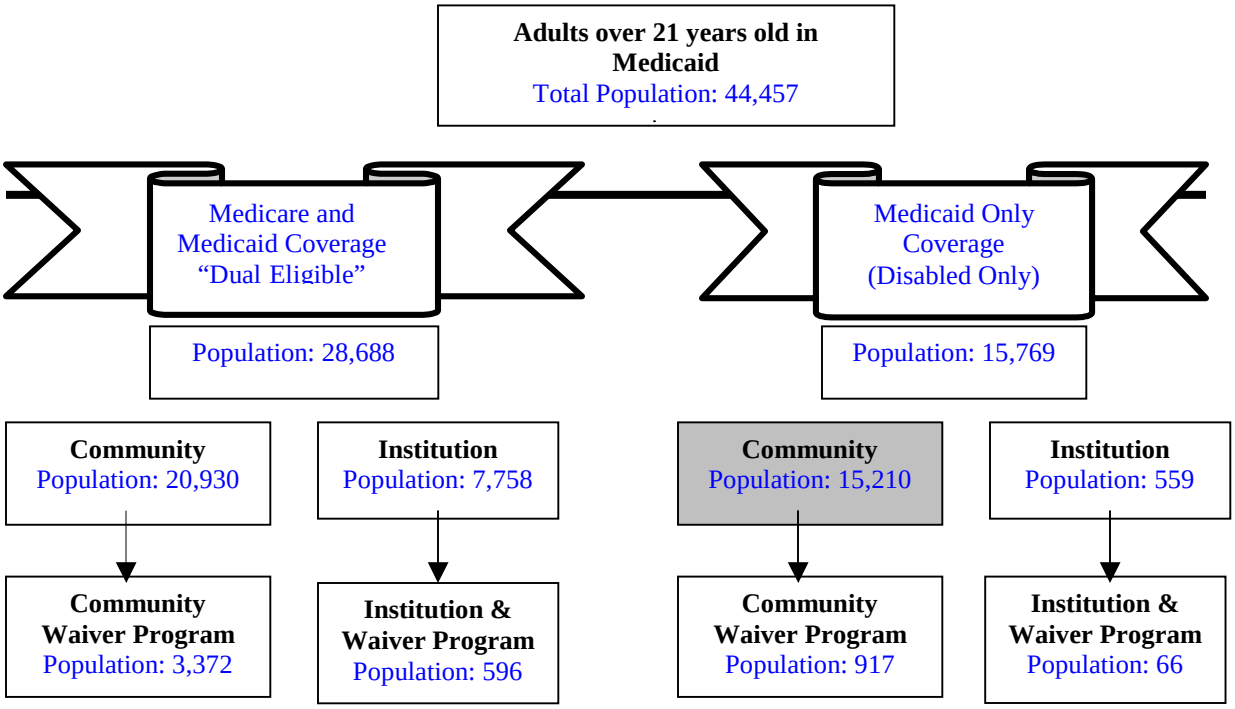
DHS began to implement the managed care program in a phased-in approach. Programs were designed to meet the health care needs for specific populations in Medicaid. Today, the managed care program development for adults with disabilities will continue to address the gray areas of unmet needs and specifically, for the eligible population of adults with disabilities. Future development of managed care programs will continue to transform the gray areas of unmet needs into models of care that promote access to a medical home to maintain wellness and independence in the community.

Section 1.3 Process and Strategy

Identification of Population:

The demographics of Medicaid adults with disabilities are illustrated below.

Figure 1.4 Population Demographics of Elderly and Disabled Adults in Medicaid SFY 2004[3]



Source: MMIS SFY Eligibility Data from Paid Claims

In Rhode Island, Medicaid-only eligible adults with disabilities living in the community accounted for the highest rate of expenditure growth from SFY 2003 to SFY 2004. To ensure a successful program implementation, DHS recommends a phased approach within the eligible adult population, focusing initially on the **15,210 adults with disabilities who are Medicaid eligible only and are currently living within the community**. The population of non-dually eligible adults with disabilities in Medicaid that live in the community represents 34% of the total population of elderly and adults with disabilities in Medicaid.

The implementation of managed care program options that would improve the health care outcomes and prevent possible transition to an institutional setting make selection of this segment of the population a logical choice**.** The managed care options must address

[3] Aggregate data from MMIS SFY 2004 paid claims for elderly and disabled. Medicaid only does not include elderly. Institution is defined as in nursing home > 30 days and < 90 days. Waiver programs are a subset of community or institution population Institution & Waiver Program refers to people who had both waiver and nursing facility services.

access to quality, customer-focused health care that promotes medical home, with an emphasis on preventive and primary care and evidence-based practice models. The concept of a medical home will foster coordination of health care services designed to meet the needs of the individual. The delivery of health care services will be achieved through contractual specifications, with specific quality measures and monitoring oversight accountability.

Department's Preparation For The Report

At the department level, the Medicaid Director and senior staff have identified the planning and implementing of these managed care options to be a top priority for the fiscal year. DHS has assembled an expert team with breath and depth of knowledge of adults with disabilities, chronic care medical management, managed care program development, financial modeling, implementation strategies, and operations and program evaluation. As a result, extensive planning for this initiative has been conducted. DHS has conducted cross-departmental meetings, outreached to interested stakeholder groups, examined current managed care programs in Rhode Island and researched managed care program development in other states. This combination of the various outreach efforts and research informed our proposal of the managed care options.

Strategy

The Department's strategy proposes a phased-in process, with an initial focus on a highly vulnerable segment of the eligible population: 15,210 Medicaid only adults with disabilities. The strategy also (1) utilizes the experience gained from successful, existing managed care programs in Rhode Island, (2) incorporates feedback from stakeholders, (3) capitalizes on collaborative opportunities with other statewide initiatives, and (4) builds upon lessons learned from other states in managed care program development.

Experience From Rhode Island

DHS has encouraging results from two existing Rhode Island programs. The Connect Care program, a DHS-administered care management and wellness program, is a customer-focused health care program for adults with chronic medical issues. Expansion of this successful health care model to a broader population of the adults with disabilities population is a logical progression and allows the Department to build upon the success of this existing program.

The DHS voluntary managed care program for Children with Special Health Care Needs (CSHCN) provides experience with a health plan option that can be used as a basis for a managed health care model for adults with disabilities. A comprehensive health plan, coordinating flexible access, quality services, and cost efficient service delivery, will meet the needs of the consumer while adhering to contractual performance standards and costs.

The implementation and enrollment problems associated with Medicare Part D present unfortunate precedence. To be successful, the managed care health options plan must encompass multi-faceted services delivery with a phased-in approach. In this way, we can build on success, modify the health care options as experience is gained, and add infrastructure support as needed.

Stakeholder Input

To ensure as much input as possible in the program design, the DHS team conducted over 20 community forums on Managed Care Options for Adults with Disabilities. Announcements were mailed to over 300 stakeholder entities, with 255 consumers, providers, advocates, and representatives of health plans, state agencies, and CMS attending the forums. Additionally, the DHS team met specifically with several groups representing a range of primary care providers. These included the Primary Care Advisory Committee, the Rhode Island Medical Society, Lifespan, and both the medical directors and the Board of Directors of the Rhode Island Community Health Centers. (See Appendix A and Appendix B)

This valuable input guided DHS in the development of creative health care solutions and program options to meet the unique needs of adults with disabilities. Building a successful program will require a shared vision from key stakeholders.

Collaboration With Other Statewide Initiatives

The convergence of various statewide initiatives to improve the health care delivery systems in Rhode Island provides yet another platform from which to build a successful health care system for adults with disabilities on Medicaid. DHS actively supports these initiatives, which will foster alignment of the managed care program options with the on-going activities of projects such as the RI Chronic Care Collaborative and the Governor's Health Reform Agenda. Capitalizing on the groundwork, momentum, and experience from these initiatives will improve the likelihood of success, reduce duplication of effort, and increase the opportunities for cost efficiency. We are also examining opportunities to coordinate this initiative with program initatives contemplated at MHRH.

Experience From Other States

DHS has conducted extensive research of other states experiences in developing managed care programs for adults with disabilities and has incorporated information gleaned from this important research. Utilizing the lessons learned from successful programs in other states will increase the successful implementation of a managed health care approach for Rhode Island.

The success of Rhode Island's managed care health program for adults with disabilities will be critical to the overall future of Medicaid, where the goal of value-based purchasing will achieve a balance between quantity, quality, and the cost of health care services.

Section 1.4 Report Summary

A thoughtful and measured approach, encompassing core values and guiding principles with input from key stakeholders guides the DHS team in addressing the mandate of this legislation. A successful program of managed care options for adults with disabilities on Medicaid will ensure quality, affordable, consumer-focused health care choices. The program components detailed in this report are as follows:

- Current Medicaid service delivery for adults with disabilities, including the population served, utilization, and expenditures and trends. The focus will be voluntary managed care choices for Medicaid only (non-dually eligible) adults with disabilities living in the community.

- Lessons learned from Rhode Island managed care programs and from other state's experiences in developing programs for adults with disabilities in Medicaid.

- How DHS will incorporate the lessons learned from other states and the strengths of the Rhode Island managed care initiatives in operation into the program design.

- Opportunities to create partnership with other statewide health care initiatives.

- Core values and guiding principles used by the DHS development team.

- Recommendations of managed care options for adults with disabilities in Medicaid. The models include a PCCM model, which is an enhanced version of the Connect Care program and a comprehensive health plan option, including projected costs.

- Overview of the implementation plan of the recommended managed care options.

- Conclusion of the issues, including barriers and recommendations.

Section 2. Health Care Delivery For Adults With Disabilities In Medicaid

Section 2.1 The Current State Of Medicaid For Adults With Disabilities

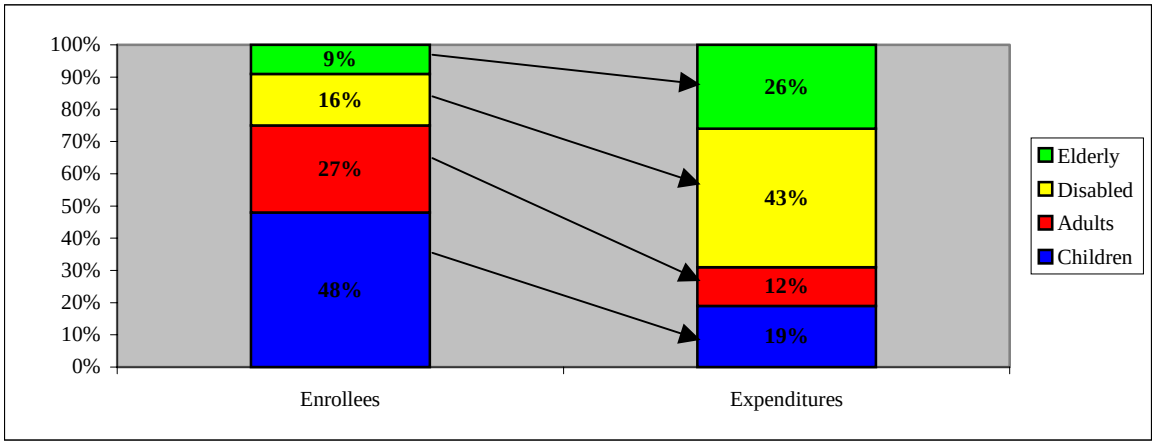
The National Landscape

Created by Congress in 1965 as Title 19 of the Social Security Act, Medicaid is the largest government health care program in the United States. In fiscal year 2004, total Medicaid federal spending was just over $300 billion and Medicaid covered over 52 million people. Medicaid accounts for 1 out of every 6 dollars spent on personal health care in the US, and accounts for one in every three births. Medicaid is an entitlement program operated as a joint federal-state partnership, with states receiving matching funds from the federal government for every dollar the state spends.

Medicaid is the primary source of health and long-term care coverage for over 8 million low-income Americans with disabilities and chronic illnesses. This includes coverage for mental health and substance abuse services – Medicaid accounts for 44% of public mental health spending[4].

There are several pathways for a person to become Medicaid eligible. For people with disabilities, their pathway to Medicaid is almost always paved with a combination of poverty and disability. A person who is low-income and disabled and collects Supplemental Security Income (SSI)[5] is automatically enrolled in the Medicaid program. Individuals who are over age 65 and who are low-income also qualify for Medicaid. Health care policy experts often refer to the "70/30 rule" when discussing Medicaid spending versus Medicaid eligibility, meaning 70% of the Medicaid expenditures are for 30% of the Medicaid population. This phenomenon is illustrated if Figure 2.1.

Figure 2.1. National Medicaid Enrollees and Expenditures by Enrollment Group, 2003



[4] Medicaid: A Primer. The Kaiser Commission on Medicaid and the Uninsured. July 2005.
[5] SSI is a federal income assistance program for disabled, blind or aged individuals that are independent of the individuals' employment status.

Medicaid In Rhode Island – Population And Expenditures

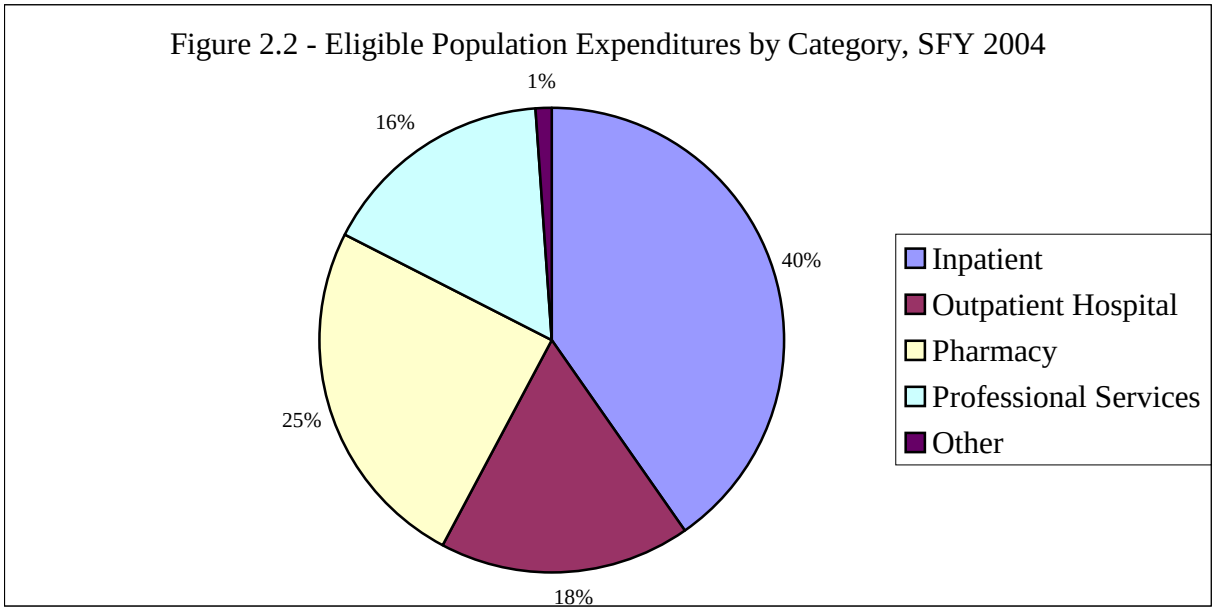
In SFY 2004, there were 44,457 elderly and adults with disabilities on Medicaid in Rhode Island. Approximately 8,316 adults reside in nursing homes, while the remaining 36,141 live in community settings (i.e. group homes, with families, or independent housing). Close to 45% of all adults with disabilities and virtually all elders qualify for Medicare in addition to Medicaid, and receive most of their medical care through Medicare.

The eligible population for enrollment in a managed care program is the 15,210 adults with disabilities living in the community who have Medicaid only coverage (non-duals). Adults with disabilities living in institutional settings like nursing homes or with dual Medicare and Medicaid coverage are excluded from this first phase of planning. This is discussed further in Section 5.1

Expenses for all adults with disabilities and elders in Medicaid were approximately $914 million in SFY 2004. When compared with all Medicaid populations, adults with disabilities and elderly constitute 25% of the beneficiaries and 66% of the expenditures.

Total spending for the eligible group (15,210) in state fiscal year (SFY) 2004 was almost $193 million. This corresponds to a per member per month (PMPM) amount of $1,057. As Figure 2.2 demonstrates, the majority of spending occurs in hospitals and pharmacies[6].

Figure 2.2 - Eligible Population Expenditures by Category, SFY 2004

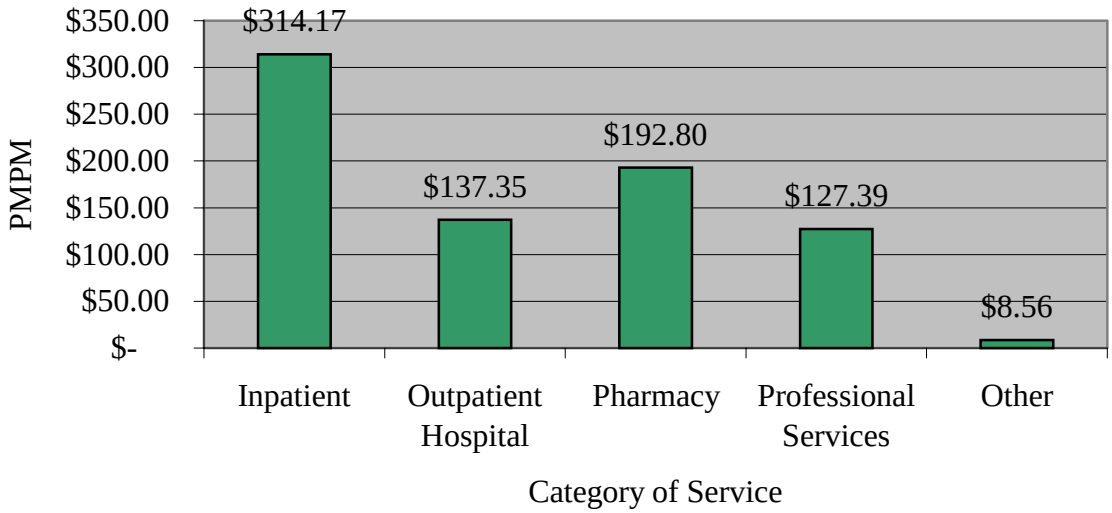


Note: Professional services include physicians, DME, x-rays, ambulance, and several other services. Traditional health plan services only shown here.

[6] Source: Rhode Island Medicaid Management Information System (MMIS)

When adjusted for membership, the PMPM expenses for those eligible for managed care enrollment are highest for inpatient services, and pharmacy services.

Figure 2.3 - Eligible Population PMPM Expenses, SFY 2004



Note: These expenses are for services considered "in-plan" and amount to a total PMPM of $780.27. The PMPM for the eligible population, including "out-of-plan" services like long-term care supports, is $1,058. In-plan and out-of-plan services are defined in Section 6.

Population Common Diagnoses

The most common diagnoses for adults with disabilities on Medicaid are listed in descending order below in Figure 2.4. It is important to recognize that several of these diagnoses are behavioral health related, which speaks to the high level of co-occurring physical and behavioral health disorders prevalent in the eligible population. In SFY 2004, the common/costly primary medical condition affected 11,784 unique individuals, representing 77% of adults with disabilities living in the community.

Figure 2.4 Number of unique eligibles within the eligible population (15,210) who have the following conditions Total Eligible Population 15,210	Number of individuals* with this diagnosis	
	SFY04	SFY05
Common/ Costly Primary Medical Conditions Total	**11,784**	**12,380**
Hypertension	3532	3744
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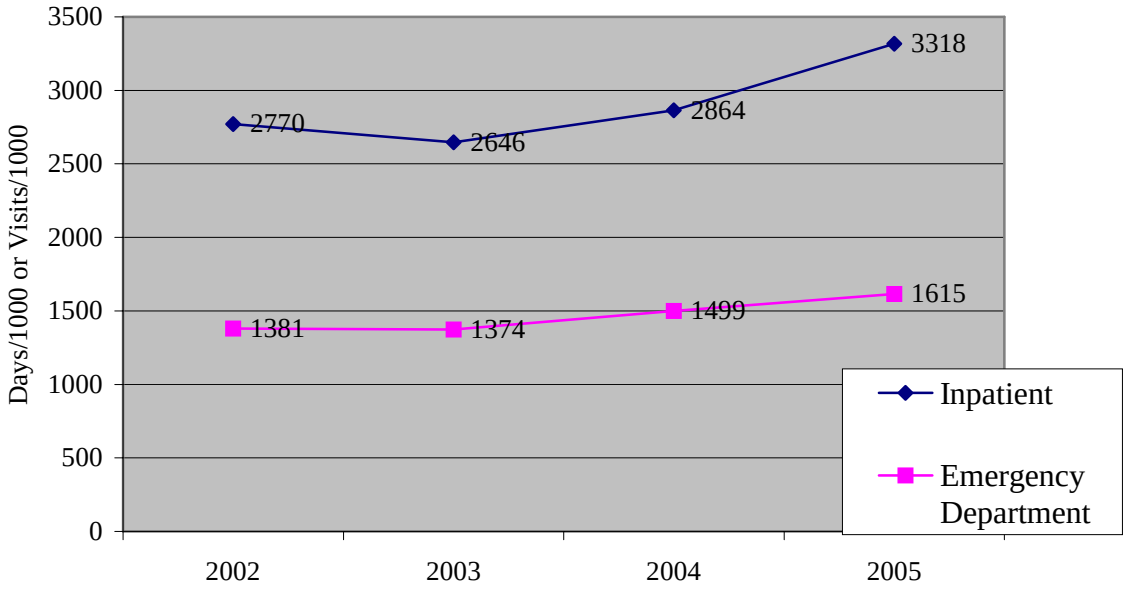
Post Traumatic Stress Disorder	453	445
Bipolar Disorder	230	202

Source: MMIS and DUR Board Data 2004 and 2005
* Individuals could be in more than one category

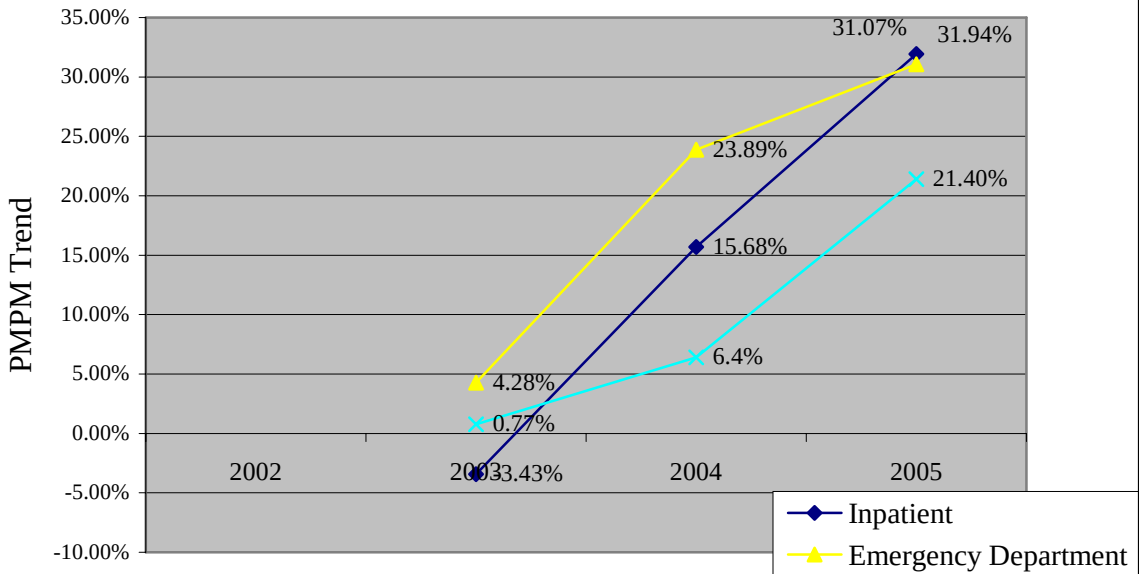
As depicted in Figures 2.5 and 2.6 below, emergency department and inpatient hospital utilization rates and costs for the eligible population has increased substantially over the past several fiscal years.

Figure 2.5 Target Population Utilizaton Trends by Category, SFY 2002-2005



Source: MMIS data extract, March 6, 2006

Figure 2.6 Target Population Expense Trends by Category SFY 2002-2005



Source: MMIS data extract, March 6, 2006

Medicaid In Rhode Island – A Systems Overview

The Department of Human Services (DHS) is the designated single state agency with responsibility and accountability for the Medicaid program in Rhode Island. DHS shares stewardship for Rhode Island Medicaid with these other agencies:

- Department of Mental Health, Retardation and Hospitals (MHRH)
- Department of Children, Youth and Families (DCYF)
- Department of Health (DOH)
- Department of Elderly Affairs (DEA)
- Local Education Agencies (LEAs)

Coordination among all these state agencies is critical for de-fragmenting the delivery of health care for adults with disabilities. In an attempt to coordinate across state agencies, Governor Donald Carcieri issued an executive order (EO 05-21) creating the Executive Office of Health and Human Services (EOHHS) on December 2, 2005. The Secretary of EOHHS coordinates the administration and financing of all health care benefits, human services, and programs including those authorized by the Medicaid State Plan.

As Secretary Jane Hayward noted in her January 2006 presentation to the Joint Committee on Health Care Oversight, "Medicaid is complicated." There are several state agencies that have administrative responsibilities for adults with disabilities and there are various eligibility pathways into the program. Figure 2.7. Illustrates the inter-agency relationships and the services they purchase or provide for these adults.

Figure 2.7. Medicaid Services Purchased or Provided for Adults with Disabilities[7]

Agency	Service Purchased/Provided
DHS	• Basic Medicaid services through direct pay to fee-for-service providers • Home and community-based services (four 1915c waivers)
MHRH	• Behavioral health services to adults with severe and persistent mental illness • Substance abuse treatment • Certain home and community based services including group homes for adults with developmental disabilities and mental retardation (MHRH 1915c waiver) • Slater Hospital (inpatient adult psychiatric and general long-term care hospital)
DEA	Certain home and community based services (DEA 1915c waiver)

[7] RI Medicaid Program Annual Report, Fiscal Year 2004

DOH	• Targeted case management for people with AIDS

Home and community-based services and behavioral health service systems are described in more detail below.

Community-Based Long-Term Care Services In Rhode Island

Some adults with disabilities receive community-based long-term care services through one of six 1915c home and community-based waiver programs operated by DHS. A description of each of these waiver programs, and the departments that operate them, is described in Appendix D.

Behavioral Health Services In Rhode Island

The Department of Mental Health, Retardation, and Hospitals (MHRH) is the mental health authority for adults in Rhode Island and funds all substance abuse services for both children and adults. Funding sources for MHRH are Medicaid, a block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), and state-only dollars.

In the Medicaid state plan, certain clinical providers provide behavioral health care and are reimbursed by DHS. These services are located in the following settings:

- Federally Qualified Health Centers (FQHCs)
- Outpatient Hospitals
- Inpatient at Acute Psychiatric Hospitals (under 21 and 65 +)
- Physician's Office
- Pharmacies
- Community Mental Health Centers (CMHCs)

There are also several provider types that are not reimbursed through the Rhode Island Medicaid state plan, including psychologists, psychiatric nurses, or counselors with Masters in Social Work (MSW) and are outside of the CMHC delivery system.

MHRH provides both inpatient services through the Eleanor Slater Hospital and community-based services for people with the following issues:

- Serious and persistent mental illness (SPMI)
- Substance abuse and addiction
- Developmental disabilities
- Serious long-term physical illness

Community-based services are provided primarily through a network of eight Community Mental Health Centers (CMHCs) in Rhode Island. CMHCs provide a combination of short-term, outpatient, urgent assessment and counseling, as well as long-term community supports, such as mobile treatment teams, for approximately 4,500 people with SPMI.

This brief system description highlights the fragmentation that consumers face when they seek health care services in today's Medicaid FFS system. Actual feedback from stakeholders is offered in Section 2.2, which follows.

Section 2.2 Stakeholder Issues With Current Medicaid Service Delivery System

DHS conducted an extensive outreach effort to describe the program initiative and to seek input from the various interested parties to guide in the development of the managed health care options for adults with disabilities living in the community. Over 20 community forums were held, with 255 consumers, providers, advocates, and representatives of health plans, state agencies, and CMS attending the forums. By invitation, presentations were given to the Rhode Island Development Disabilities Council and to Rhodes to Independence. With the aim of reaching a wide consumer base, the DHS team held additional forums in community locations affiliated with adults with disabilities.

In an effort to understand the specific issues of the provider community, the DHS project team also conducted presentations and feedback sessions with several groups of providers, including:

- The Primary Care Advisory Committee (PCPAC), representing both a mix of primary care disciplines and private and health center physicians. The PCPAC also serves as an advisory committee to the R.I. Department of Health on issues concerning primary care.
- The Rhode Island Medical Society
- Lifespan
- Medical Directors of the R.I. Community Health Centers
- Board of Directors of the R.I. Community Health Centers
- Medical Directors of the R.I. Community Mental Health Centers
- Administrators of the R.I. Community Mental Health Centers
- Medical Directors at MHRH

Information gathered from the forums is provided within Section 2.2. The feedback is grouped into the following topic areas:

- Access
- Benefits
- Coordination

Access

Access to providers of quality, coordinated, consumer-focused health and social services was raised during every forum. Additionally, physical access was raised as an issue, especially in the form of transportation.

Difficultly in finding a provider to treat adults with disabilities within a community primary care setting was communicated as a barrier. Feedback from the attendees indicated that low provider reimbursement was the leading cause for providers to not take patients with Medicaid. Input from the providers included the premise that adults with disabilities and chronic medical illnesses often require a high degree of coordination of services that are often not reimbursable to the provider. The non-payment for professional services, such as case management and phone conferences with other treating providers, was reported as an inherent disadvantage to managing a patient's care. In addition, for people with co-occurring conditions, improved access to evidence-based clinical treatment guidelines available for providers on treatment of both diagnoses would lead to improved health outcomes.

With respect to behavioral health services, the Community Mental Health Centers (CMHC) provide covered services under the FFS Medicaid program. Further, CMHCs are the primary outpatient provider network available to FFS Medicaid consumers. The CMHCs focus the majority of their expertise and resources on enrollees identified as having serious and persistent mental illness (SPMI). Serious capacity issues exist in the CHMCs. Consumers reported being placed on waiting lists for less intensive behavioral health services. This often results in outpatient behavioral health service needs being unmet, which can lead to more costly future treatment solutions. Consumers and providers alike expressed a need for creative approaches to improve the current infrastructure and to build increased capacity of behavioral health services in Rhode Island.

Therapeutic services, such as physical therapy, occupational therapy, and speech therapy, are covered only in the institutional setting or through a visiting nursing agency and are designed for rehabilitation rather that functional stability. Flexibility in accessing the services that promote functional maintenance would improve the wellness and independence of the member. Also, barriers were identified related to the physical office setting, such as offices not meeting the Americans with Disability Act Accessibility Guidelines (ADAAG) for accessibility.

Many people are not aware of the transportation services that are available for covered medical services. The transportation to medical services can be coordinated through the RIde program and is available until 2:00 P.M., Monday through Friday. RIde appointments for the transportation to a medical appointment must be made two weeks in advance. People can contact the DHS transportation line at EDS to arrange for transportation services, generally with a 24-hour advance request. Transportation arrangements for "on demand" urgent requests are difficult to schedule, but are available. Creative approaches to improving the transportation benefit capacity of the RIde program for this population will ensure that the member keeps the appointment and has access to a cost-efficient and effective transportation infrastructure.

Benefits

Flexibility in rendering Medicaid covered benefits that support a holistic approach to cost-efficient health care was a repeated theme expressed by consumers and providers alike. Areas of concern for adults with disabilities include physical therapy, occupational therapy, speech therapy, alternative therapies, dental, vision, and transportation services. Many attendees stated that DHS needs to focus on covered benefits designed to deliver services to maintain functional independence and wellness.

With respect to therapy, the collective recommendation from the forums was to provide services that maintain functionality and that would avert more costly future treatment. These recommendations included delivering the services in the community, rather than in an institutional setting, and providing benefits, such as aquatic therapy, that would improve the functional wellness of the individual and promote exercise as a healthy lifestyle choice. The shift to the community-based delivery of therapy services would reduce the additional cost of providing transportation to the outpatient institutional setting.

Requests were made for an improved vision benefit, specifically with improvements to the quality of the frames that are covered under Medicaid. Another suggestion expressed often was an expansion of coverage for hearing aids, so that, where required, a hearing-impaired individual could obtain hearing aids for both ears, not just one.

Unmet oral health needs, as highlighted in the Unmet Health Care Needs – 2002 Focus Study, continues to be a highly identified issue by this population. Many community dental providers do not accept Medicaid patients, leaving this population to travel outside of their community to obtain treatment. Often, consumers do not utilize the covered preventive dental services. Lack of preventive oral health services can lead to the onset of an acute oral episode that would be treated in a costly setting. Consumers and providers reported that the side effects of some prescribed medications impact the oral health of the individual. Oral health services are a critical need for these individuals. While data is not yet available to support this conclusion there is a growing body of evidence pointing to increased acute utilization and co-morbidity resulting from untreated oral health conditions.

Coordination

A frequent theme heard from attendees at the forums was that the system of health care for adults with disabilities must be designed to weave together the blended funding of the delivery of medical, behavioral, dental, and ancillary services to meet the unique and individual needs of the consumer. Many adults with disabilities have chronic care management needs that require the integration of the medical and social services that promote wellness and better meet their complex health care needs. Early identification of chronic medical conditions and treatment in a community setting can lead to better health

outcomes and avoid unnecessary and costly hospitalizations and nursing home settings of care.

The services delivered to adults with disabilities and people with chronic medical conditions have traditionally been rendered through treatment during a medical crisis. The delivery of these services in an acute environment often does not include the coordination of the wide spectrum of services needed to treat the complex medical conditions. In this population of 15,210 adults with disabilities, almost 30% of the individuals suffer from both mental and physical conditions. Their multiple health problems, which are often compounded by isolation and depression, result in complex needs for medical management, medication management, supportive chronic care services, and mental health services. This population would benefit from a stable connection with a medical home, reinforced with ongoing care coordination. This coordinated approach needs to include a consumer-focused, holistic approach to a chronic care medical model with a focus on screening and prevention. The flexibility to shift the focus of the care to support a coordinated community-based service delivery option will lead to a more cost-effective service delivery system that meets the needs of the individuals.

For adults with disabilities, transition from the pediatric practice setting to an adult-focused practice was also mentioned as a difficult process. Pediatric practices tend to treat the child from a holistic standpoint. Adult practices are generally not as familiar with the range of specific disabilities and the differing treatment approaches available.

Attendees frequently mentioned the lack of culturally competent providers, who will listen to the person with the disability and respect their knowledge of their individual disability, as a barrier to consumer-focused care. Improvements in the availability of educational materials for the consumers, providers, and other caregivers on disability issues, treatment protocols, chronic disease management, self-management, and support services were recommended.

There is a need for coordination between medical and behavioral providers, especially to avoid adverse drug reaction. If a provider gives a patient a prescription sample, the sample will not be listed in the pharmacy claims system. As the sample was not in the DHS pharmacy system, the clinical edit would not identify that the patient had multiple prescriptions that might create an adverse drug reaction.

An expressed need for improved coordination between medical and ancillary providers, such as Durable Medical Equipment providers, was voiced. Examples provided during the forums highlighted the delay in the delivery of authorized specialized wheelchairs or other equipment, which can take anywhere from six weeks to six months. Provider specific delivery dates of authorized equipment could be implemented to address these delays.

Consumers reported that coordination of support services in the community would enhance the quality of life and avoid duplication. Current community services available

to support this population allow the individuals to reside in the community, rather than in a nursing home or institutional setting. Creative program development is necessary to coordinate all of the services that providers are rendering to the individual. It is likely that a member will have several entities coordinating different aspects of the member's care. An appropriate lead entity to coordinate these services will ensure the member is receiving quality, customer-focused care that will lead to improved quality of life in the community.

Section 3. Lessons Learned From DHS And Other States

Section 3.1 Benefits Of Medicaid Managed Care For Adults With Disabilities

For many states, managed care models have been seen as an antidote to the uncoordinated and fragmented Medicaid fee-for-service delivery system. Managed care can offer people with disabilities, states, and providers a variety of advantages aligned with the "management of care." Some of these are listed in the table below.

What Managed Care Can Offer – A Summary

Consumers	• Access to a medical home • Access to enhanced provider network • Prevention-focused primary care • Improved quality of life in the community instead of an institution • Coordination of services • Additional/enhanced benefits or services
State Purchasers	• Purchasing systems of care based on value • Greater accountability and standards of care • Health care utilization in most appropriate setting • Cost containment through moderation of expense trends
Providers	• Assistance with care coordination for complex clients • Better disease management • Higher and/or steadier reimbursement
Finance	• Budget Predictability • "Cost shift" to fund new services and service delivery infrastructure

Consumers

In today's Medicaid FFS system, adults with disabilities face a fragmented and uncoordinated approach to health care delivery. Consumers have little choice but to navigate the health care system on their own. Some consumers need assistance from caregivers or, if they are fortunate, from family members to navigate the health care

system. Consumers have difficulty accessing physician and specialty services. Some physicians refuse to accept Medicaid clients. When clients do find a doctor who will accept Medicaid, the focus tends to be on acute episodic care.

Consensus on a definition for "access" specific to people with disabilities is not always realistically obtainable, but the definition below is a good start:

> Access refers to the ability of individuals or groups to receive needed services from the health care system in a timely fashion. This may include the availability of a particular service, awareness by individuals that the service exists, how to obtain it, and the ability to get the service in a reasonable amount of time. Health care access for people with disabilities includes an additional level of physical and communication supports necessary for them to benefit from quality health care[8].

For individuals in Medicaid FFS, managed care can offer solutions to many of these complex problems as a management of care vehicle. Access is improved through contracting with an expanded provider network. These providers are given the appropriate supports that will allow them to spend additional time with their patients to discuss preventive issues and foster the creation of a medical home. Intrinsic to managed care models is the availability of customer/member services. Customer/member service staff assists the consumer in getting the care they need, including help coordinating access to enabling services like transportation and interpreters. Care coordination is also an essential ingredient to a managed care program – not only coordinating the medical needs of a member, but their psychosocial needs as well (e.g. housing, mental health, substance abuse, etc.).

State Purchasers

States often adopt managed care approaches to serve Medicaid clients with special needs as a cost-savings initiative. While cost-savings/cost-containment is achievable in the long-term[9], it is unrealistic to expect significant cost savings in the short-term. Converting from FFS to a managed care model can often create what is called the "woodworking effect". This phenomenon occurs when consumers who previously could not access or were not aware of services, suddenly "come out of the woodwork", or care coordinators uncover issues and unmet needs that previously went unnoticed or unaddressed.

In addition to long-term cost containment and cost predictability, states adopt managed care approaches in an effort to shift from a payer of claims to a purchaser of services. As a purchaser, a state can contract with qualified vendors or networks of providers and impose performance standards on those contractors. Contracting is a vehicle for improved state oversight and monitoring against evidenced-based program standards and

[8] Medi-Cal Redesign Aging and Disabilities Workgroup Presentation. April 2004.
[9] Savings usually begin to occur in the third full year of a program.

performance measures leading to a management and coordination of care versus managed care.

Providers

There is a general reluctance in the physician community to increase the number of Medicaid patients they see in the Medicaid FFS system. The most commonly cited reason for this reluctance is inadequate reimbursement. Contributing factors include the high rate of "no-shows" by Medicaid clients, and the lack of support to coordinate a patient's many complex medical and psychosocial needs.

Given budget constraints, it is difficult for DHS to increase rates absent a contracting structure that ties those increases to enhanced performance and anticipated cost offsets. However, managed care organizations and PCCM programs can offer providers enhanced payment rates as a contracting and recruitment strategy. In addition, both options offer physicians practice supports that include nurse case management to assist them with disease management and care coordination. Managed care member services staff assists clients with obtaining necessary transportation and interpreter services thus reducing the no-show rate at the provider's office. Managed care strategies provide the "investment risk" infrastructure to support the transition of funding from more acute setting to more appropriate setting.

Section 3.2 Lessons Learned From Rhode Island's Connect Care Program

Background

Connect Care is a care management and wellness program designed for a medically high-risk population, was launched in 2001 by the DHS in partnership with Neighborhood Health Plan of Rhode Island (NHPRI). DHS contracts with NHPRI to provide nurse care managers, who work closely with the consumer and a lead physician (frequently the primary care physician) in coordinating care planning and care management. The nurse care manager also has access to an interdisciplinary team of professionals for complex care planning needs. The direct nature of the relationship between the nurse care manager and the consumer creates the sense of a "medical home." This promotes improved management of chronic conditions by increasing preventive visits, leading to improved health care outcomes, and overall well being. In addition to traditional Medicaid reimbursement, physicians receive additional reimbursement for up to two care planning conferences per enrollee, per year.

Population

Connect Care was designed to bring quality, access, and coordinated care to some of the state's most compromised and challenged consumers. The enrolled beneficiaries are fee-for-service Medicaid adults, over 21 years old, who (1) have a high utilization of acute inpatient and ED services, (2) have specific chronic diseases (for example, diabetes), (3)

live in the community, and (4) are traditionally treated within an ambulatory setting. This population, which is often socially isolated and has multiple chronic medical and behavioral health conditions, presents unique challenges for any medical support system. To date, Connect Care has enrolled over 500 individuals, with 230 members currently active.

Design

Connect Care was originally developed in response to concerns about the cost and the quality of care for fee-for-service Medicaid adults. The original program goals were:

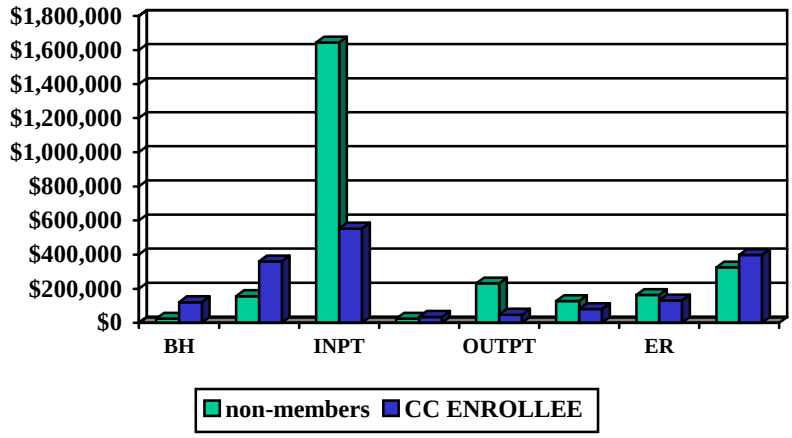
- Implement a care management program for approximately 300 adult Medicaid consumers;
- Improve the wellness of chronically ill consumers by engaging, educating, and empowering them to self-manage and self-advocate their care;
- Use community-based nurse care managers to work actively with the consumers through outreach and intervention when necessary;
- Promote primary and preventive care through a "medical home;"
- Shift care, as appropriate, from costly inpatient settings to community and ambulatory settings;
- Increase access to behavioral health services; and
- Improve disease-specific medication compliance

Outcomes

The Connect Care Program began enrollment of individuals in January 2002. Since then, the program has decreased avoidable hospitalizations; improved access to providers, services, and care; and, most importantly, improved quality of life for its participants. Key measures of the program's success continue to be provider and member satisfaction, specific disease management health care indicators, and clinical outcomes.

In SFY 2003, a subgroup of 45 Connect Care enrollees experienced a reduction of $1 million acute hospitalization expenses when compared with a control group of 45 recipients who were eligible for the program but refused enrollment. The SFY 2003 PMPM for these enrollees was $3,395, 32% less than compared with a PMPM of $4,995 for those non-enrollees. Preliminary program measures have indicated an increase in home- and community-based services, behavioral health visits, and pharmacy utilization.

Comparison
Connect CARRE Cohort V Control Group Non-members (N=45)
Calendar year expenses for 2003 (source MMIS)



Additionally, the program indicators for disease specific measures, such as diabetes, congestive heart failure, sickle cell anemia, chronic obstructive lung disease, and depression for the 45-member cohort for SFY 2003 are encouraging and will serve as a quality improvement focus. (Appendix E and Appendix F)

A member satisfaction survey is ongoing, and preliminary results are very positive in the areas of improved quality of life and self-management. A provider satisfaction survey elicited a small response, therefore has not been compiled. The survey will be revised and re-administered, as provider feedback is vital to the program success.

The Stories of Connect Care

"Tom" is a young man in his early 30's who was referred to the program by his Long Term Care DHS social worker. His Long Term Care DHS social worker was very concerned about him because he was not managing his diabetes in addition to his developmental disabilities. When the Connect Care nurse made a home visit, she discovered he was living alone, didn't understand how to recognize dangerously low blood sugar levels, had no food in his apartment, and had no money to buy any.

The nurse care manager immediately obtained food from the local food bank for the weekend, notified the physician of the situation, obtained visits from a home care nurse, provided referrals to community-based resources for ongoing needs, and successfully referred this young man to the local ARC for services for developmentally delayed individuals.

As a result, the client now attends daily programs at ARC where he receives two meals every day, is better able to self manage his medical conditions, participates in social

events, receives assistance in finding a subsidized apartment, and has improved his health and quality of life.

"Rose" was referred to the program by her community based home care agency. She is well-educated lady in her 60's who suffered a stroke several years ago that left her with left-sided weakness and speech difficulties. "Rose" ended up having multiple emergency room visits due to frequent falls, inability to express her needs well by phone due to speech impairments, and missed medical appointments because of transportation issues.

The Connect Care nurse care manager was able to communicate with the primary care physician to obtain physical therapy, speech therapy, medical specialty appointments, and an appropriately fitted wheelchair. "Rose" was educated in the use of the EDS transportation line, and a seat lift chair was obtained from PARI to reduce falls.

Ongoing positive outcomes include a decreased incidence of falls and improved medical care, mobility, and communication. Now "Rose" enjoys a better quality of life.

Program Challenges

Numerous barriers and challenges were encountered in the implementation of Connect Care. The initial challenge was to identify an appropriate eligible population using Medicaid claims data. This required the creation of a predictive modeling search capacity that could identify Medicaid recipients meeting the program's identified population characteristics. The second challenge was recruiting physicians to participate in the program. With experience, Connect Care was modified to create physician recruiting strategies that included additional payment for care planning conferences, practice supports for managing complex and time consuming patients, and improved communication with other providers.

The third program challenge, however, continues to be recruiting and maintaining individual consumers in this voluntary program. With minimal staff and resources dedicated to this program initiative, maintaining enrollment, and encouraging enrollees to participate actively has been difficult. Recruiting efforts have included provider and community outreach, letters of invitation to targeted individuals, and use of an "opt out" strategy. The "opt out" approach was time- and resource-intensive and resulted in only a 30% enrollment of the individuals contacted. The final and most successful recruiting strategy has been the creation of an onsite nurse care manager at Rhode Island Hospital as a Medicaid quality improvement project. This bilingual nurse engages individuals at the "teachable moment" and assists with enrollment into the program. The nurse also works with hospital-based providers to improve care management and discharge planning. Enrollment is now 10 to 12 members per month.

Maintaining the active enrollment has also proved difficult. Dis-enrollment rates are high within this population. Individuals are frequently in extreme medical crisis at the time of enrollment and either die or require nursing home placement. It is also very difficult to maintain enrollee contact due to frequent changes of address and the lack of a response to

the nurse care manager's repeated outreach efforts. After two months of no response to phone calls and "call me" letters, these individuals are removed from Connect Care enrollment.

By far, the most difficult challenge has been Connect Care's efforts to engage, educate, and empower the individual to self-manage and self-advocate their needs. This culturally diverse and economically disadvantaged group is often overwhelmed with physical, mental, and social problems. The self-management program component continues to present unique and difficult challenges for the nurse care managers.

Lessons Learned

Connect Care has been operational since January 2002. Over this time, DHS has gained valuable insight into how to design, implement, and maintain chronic care programs for this complex and challenging population. These insights include:

Voluntary Enrollment

- Enrollment and outreach is time-consuming and resource-intensive
- Multiple enrollment strategies using multiple sources is necessary
- Continuous enrollment activity is critical to reach and maintain the program's enrollment goals
- Medicaid recipients are more likely to enroll if the program is introduced by a person or provider with whom they have an established relationship or during a hospitalization

Data Required

- Current and accurate demographic data is necessary
- Information on active Medicaid recipients must be kept current
- Up-dated third-party liability data is required
- A screening process for identifying high risk candidates must be developed

Care Management Issues

- Clinical assessment tools need to identify high-risk individuals as well as social problems
- Risk-stratification is required to identify and implement appropriate level of care management services and interventions
- Members need to be screened and enrolled as soon as they are Medicaid eligible since many of these individuals are already severely disabled, with multiple chronic illness and social needs

Primary Care Providers

- Low and inadequate reimbursement rates make it difficult to recruit physicians for Medicaid chronic care programs
- The needs of the Medicaid recipients within the Connect Care population are complex and time-consuming to the practice
- The high rate of no-shows in this population is a financial burden to the practice

- Medical practices have insufficient knowledge about community resources for this population
- Practices are not always culturally competent or sensitive to the needs of this population

These experiences and lessons learned from all aspects of the current Connect Care program will help inform the design and implementation strategy for the Connect Care Choice, PCCM model.

Section 3.3 Lessons Learned From The RIte Care Program

Background

RIte Care is Rhode Island's mandatory Medicaid managed care program for low-income and uninsured children, parents, and pregnant women. RIte Care continues to receive national recognition as a highly successful health care program. In 2001, the RIte Care program began enrolling children in foster care. In September 2003, RIte Care began the voluntary enrollment of children with special health care needs. Currently, only one plan, Neighborhood Health Plan of Rhode Island (NHPRI), enrolls children in foster care and children with special needs.

Population

DHS contracts with three licensed health maintenance organizations (HMOs) to enroll the 124,114 RIte Care recipients[10]. Distribution by plan is as follows:

Blue CHiP	13,879
Neighborhood Health Plan of RI - RC	68,262
• Foster Care	2228
• Children with Special Needs	4243
United Health Care of New England	35,502

Design

RIte Care had the following general goals when it was first implemented in 1994:

- Increase access to and improve the quality of care for Medicaid families
- Expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- Control the rate of growth in the Medicaid budget for the eligible populations

The goals that the State established for managed care enrollment of Medicaid-eligible children with special health care needs included the following:

- Improve access to coordination of care

[10] As of January 2006.

- Contain the growth of costs through efforts such as reducing the length of hospital stays and reducing the number of Emergency Department (ED) visits
- Improve the appropriateness of utilization of health care services
- Increase the level of consumer satisfaction with available services
- Improve overall health outcomes

Outcomes

Since its implementation, RIte Care has positively impacted several important areas of health care, including:

- The average number of physician visits per enrollee increased from 2 per year pre-RIte Care to approximately 6 per year.
- Emergency Department visits have decreased to approximately 580 visits per 1,000 Medicaid recipients, dropping from 750 visits per 1,000 recipients prior to RIte Care availability.
- 96.7% of members report having a primary care physician.[11]
- Overall member satisfaction with the program has been 95% or higher since 1996.

DHS currently enrolls children with special health care needs (CSHCN) on a voluntary basis into RIte Care. This is accomplished through an opt-out enrollment approach. This form of voluntary enrollment involves sending communication to eligible families notifying them that if they do not make an active choice to return to fee-for-service Medicaid, they will be automatically assigned to NHPRI. This has resulted in a 68% enrollment rate in the health plan. All children with special needs receive an initial health screen upon enrollment into NHPRI. This screen captures areas of medical, behavioral health, and social unmet needs. Based on their level and type of need, all CSHCN are assigned a care manager who makes regular contact with them and coordinates all their services.

Lessons Learned

With the RIte Care program, DHS has more than ten years of experience purchasing a network of health care services. In recognition of the eligible population (Medicaid adults with disabilities) for a voluntary managed care program, we recognize that the medical and psychosocial issues are far more complex than those of RIte Care members, CSHCN as evidenced by the experience gained from the Connect Care program. Therefore, a RIte Care expansion for this population may not be the most appropriate. The RIte Care experience does, however, present several lessons in health care purchasing and program design.

1. *Access to primary and specialty care prevents avoidable hospitalizations and Emergency Department visits.*

[11] 2004 RIte Care Member Satisfaction Survey results.

The RIte Care program created a medical home for thousands of children who did not previously have a primary care provider. Having a primary care provider has led to increased immunization rates and well-child visits and, subsequently, to decreased reliance on the Emergency Department as a site for primary care.

2. *A comprehensive package of benefits that includes primary care, acute care, behavioral health, and pharmacy "under one roof" reduces fragmentation of service delivery, promotes care coordination, and improves health outcomes*.

   The lesson from RIte Care is that program integrity requires an intact, comprehensive set of benefits. The ability for medical, behavioral, and pharmacy staff to communicate and to coordinate services creates the best and safest care environment for the member.

3. *Risk-based contracting with risk corridors in place creates appropriate incentives for cost containment and health care quality*.

   The Balanced Budget Act requires states to contract with plans using actuarially sound capitation rates. This federal mandate allows necessary rate increases to RIte Care health plans.

4. *Rates must be adequate to support the case-mix of the membership and benefit package*.

   Inadequate rates threaten the stability of the plan and increase the dependency on state risk-sharing arrangements.

5. *Contract oversight and monitoring by the state is fundamental to program success*.

   While DHS maintains a collaborative relationship with the health plans, it also regularly monitors activities, including reviews of quarterly grievance and appeals reports and an annual review of utilization and cost trends among the plans.

6. *Managing care for Medicaid enrollees can lead to cost containment*.

   RIte Care's cost trend of an 8% annual increase is currently less than commercial trends of close to 14%.

7. *Contracting is a powerful vehicle for requiring quality improvement and performance standards*.

   RIte Care health plans are expected to develop and measure annual quality improvement initiatives. The plans are also evaluated annually against a set of

contract performance standards, with successful scores being tied to financial incentives.

These lessons learned from DHS functioning as a purchaser in the RIte Care program, combined with the lessons learned from Connect Care in the previous section, will be applied to program design for adults with disabilities.

Section 3.4 Lessons Learned from Other States

When we look to lessons learned from other states with managed care programs for adults with disabilities, we find varying degrees of success and experience. As of 2001, 36 states enrolled at least some Medicaid-eligible adults and children with disabilities into managed care. The majority of the adults were enrolled in **mandatory**, capitated plans. In addition, several states currently enroll all Medicaid-eligible adults with disabilities into managed care programs – 1.6 million of the 20.7 million Medicaid beneficiaries enrolled in managed care are non-elderly SSI beneficiaries[12]. Other key facts are:

- 16 states use both capitated and primary care case management programs
- 14 states use only managed health plans
- 6 states use only Primary Care Case Management (PCCM) programs
- 6 states enroll more than 75% of their beneficiaries with disabilities into managed care

This section of the report provides a brief description of several state programs, both those that are fully capitated programs and those that are primary care case management (PCCM) programs, as well as one state that operates both. The section concludes with specific lessons for Rhode Island to consider as we develop a statewide solution.

Massachusetts

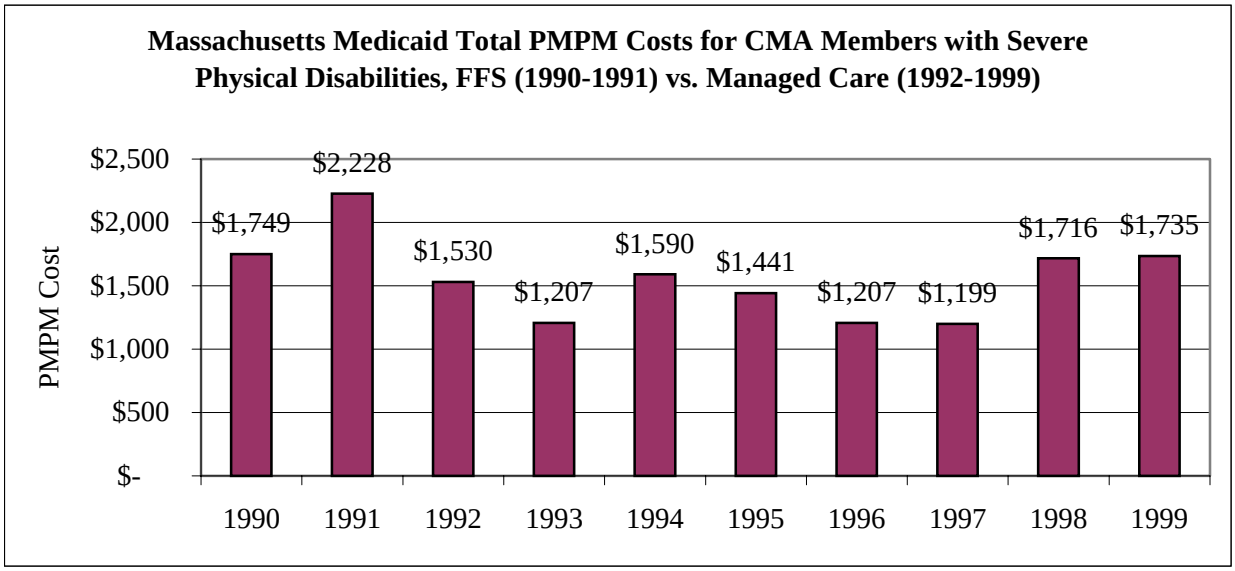
Massachusetts operates both a PCCM program called the Primary Care Clinician (PCC) Plan throughout the state and a full-risk managed care program through most of the state. Enrollment for both programs is handled by broker services contracted by the state. For the PCC Plan, Massachusetts also contracts with a separate vendor for network management and quality improvement functions. Roughly 88,000 of the Massachusetts Medicaid-eligible residents with disabilities choose between the PCC Plan or from the full-risk managed care program. Members who do not select an option are automatically assigned to the PCC Plan. The four managed care organizations participating in the Massachusetts Medicaid program are fully capitated.

In 1992, Massachusetts Medicaid contracted with the Boston-based Community Medical Alliance (CMA), a nonprofit clinical affiliate of Neighborhood Health Plan of RI (NHPRI), to begin enrolling nearly 2,000 Massachusetts residents with AIDS, severe

[12] Kaiser Commission on Medicaid and the Uninsured, March 2001.

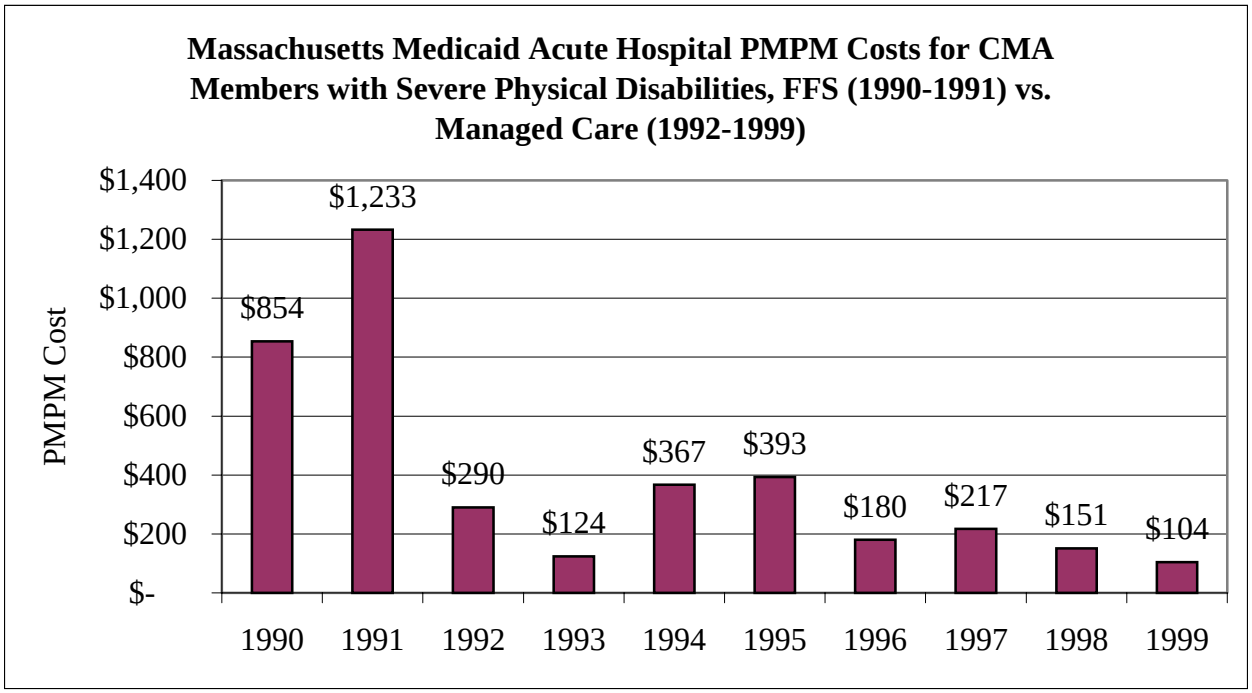
physical disabilities, psychiatric conditions, and complex chronic illness into a specialized managed care program. CMA's team approach to primary care, combined with a commitment from Massachusetts Medicaid to risk-adjusted premiums, resulted in program cost savings. As shown in Figures 3.4.1 and 3.4.2, total costs and acute hospital costs declined for CMA members after enrollment in the CMA-managed program. Massachusetts officials state that such drastic decreases are not easy to achieve but are much more likely when there is a shared goal and when there is a collaborative effort among all stakeholders—consumers, advocates, state Medicaid, health plans, and clinicians.

Figure 3.4.1



** NOTE: Starting in 1998, pharmacy was included in the program.

Figure 3.4.2.



Oklahoma

In July 1999, the Oklahoma Health Care Authority began enrolling the Aged, Blind, and Disabled (ABD) population into managed care. By October 1999, all ABD members had been enrolled into a health plan under the state's mandatory Medicaid managed care program, SoonerCare. To examine the cost-effectiveness of and satisfaction with managed care, a recent study examined 538 individuals covered under the Heartland Health Plan of Oklahoma. Comparisons were made between FFS and those enrolled in managed care in the areas of cost, quality of care, and member satisfaction levels. This study found that **managed care resulted in a 4% savings** in total medical and administrative costs. When the ten costliest enrollees were excluded from the data, the overall net cost **savings were 17%, compared to the FFS program**. When members were asked about their satisfaction with health services, 61% noted their care was better under managed care than it was under FFS. When queried about the ease of obtaining prescription drugs, 60% of the members reported it was easier to obtain a prescription through the health plan than it was under FFS[13].

Due to inadequate legislative appropriations to support health plan premium increases to actuarially sound levels, Oklahoma eliminated its SoonerCare program at the end of 2003. Since January 2004, Oklahoma has operated a statewide PCCM program for Medicaid beneficiaries. The results after one year indicate an overall program savings of $3.9 million[14].

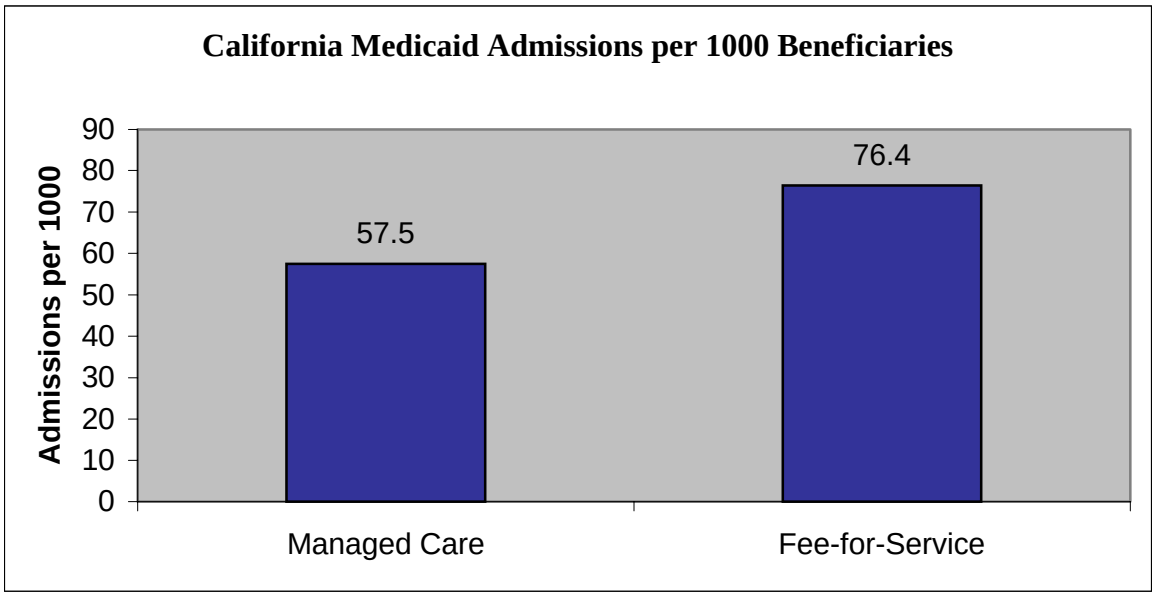
[13] Schaller Anderson, Inc. Serving the Special Program/Aged, Blind, and Disabled Population through Managed Care. Center for Health Care Strategies. April 2002.
[14] The Future: Primary Care Case Management. NASMD Fall 2005 Meeting. November 7-9, 2005.

California

Almost 200,000 non-elderly adults with disabilities are currently enrolled into capitated managed care in California. Certain counties in California operate a mandatory program, while others operate a voluntary program. California began Medi-Cal, its Medicaid managed care program, in the early 1990s. Between 1994 and 1997, the program experienced its largest program growth. In 1994, 7% of SSI-eligible Medicaid beneficiaries were in managed care. By 1999, this proportion reached 18%.

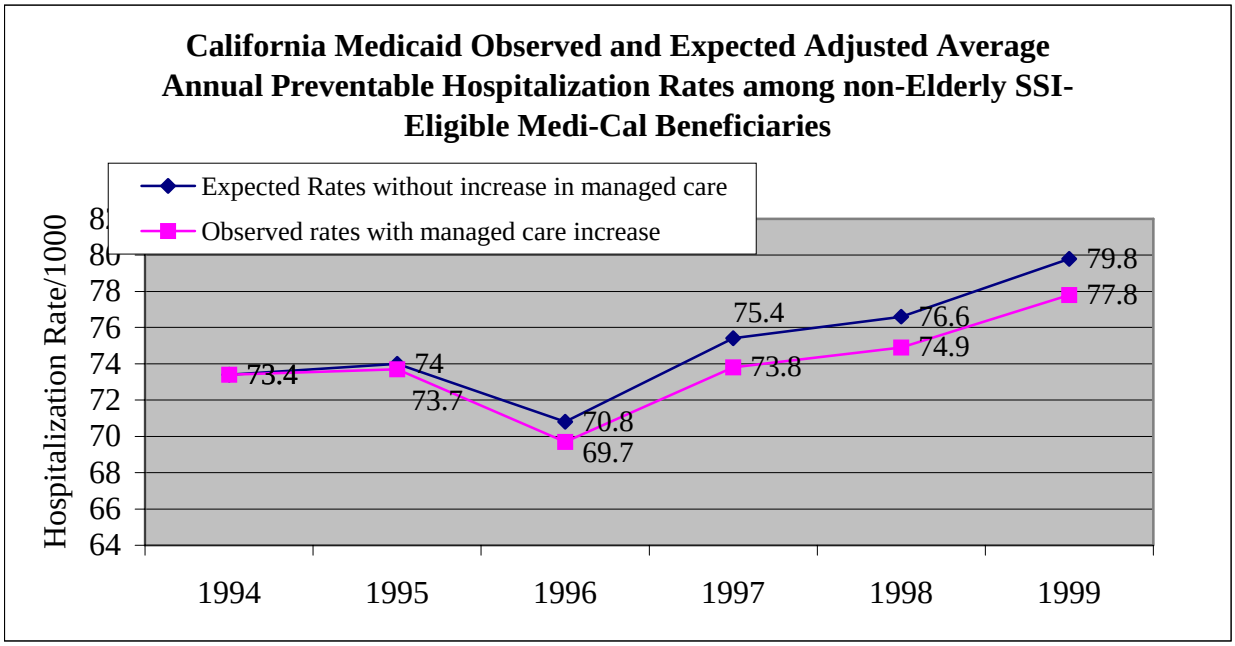
One measure of access to ambulatory care that Medi-Cal uses is the rate of preventable hospitalizations. An analysis of hospital data from 1994 to 1999 found that the number of preventable hospitalizations was significantly lower among health plan enrollees than among comparable groups of FFS enrollees. Preventable hospitalizations are those that could have been avoided if a member's condition had been well managed in an outpatient setting. This comparison is illustrated in Figures 3.4.3 and 3.4.4[15].

Figure 3.4.3. Average Annual Preventable Hospitalization Rates Among Non-Elderly Medi-Cal Beneficiaries with Disabilities, 1994-1999



[15] Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems. California HealthCare Foundation Issue Brief. August 2005.

Figure 3.4.4. Observed and Expected Adjusted Average Annual Preventable Hospitalization Rates among Non-Elderly SSI-Eligible Medi-Cal Beneficiaries, 1994-1999.



Minnesota

Minnesota Disability Health Options (MnDHO) is a specialized managed care program for working-age adults with disabilities who reside in the Minneapolis-St. Paul area. MnDHO is a voluntary program that integrates delivery of all Medicaid and Medicare services, except prescription drugs. As of January 2004, slightly more than 200 people had enrolled. The Minnesota Department of Human Services administers MnDHO and pays a capitation rate to UCare Minnesota. UCare subcontracts with Axis Healthcare for care coordination, provider relations, and member services.

While this program in small and enrollment is voluntary, several positive results have emerged[16]:

- Hospitalizations were reduced to better than half, yielding 100 hospitalizations per 1,000 members
- Hospital length of stays were reduced by more than 60%
- 90% of members reported satisfaction with their health care services, as compared with 10% prior to enrollment
- 85% of members reported receiving help managing their health care services, as compared with 5% prior to enrollment

[16] Palsbo, P. Beatty, P. Parker, P. and Duff, C. Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities. Center for Health Care Strategies. January 2004.

- 66% reported higher overall satisfaction with their primary care doctors in the year after they enrolled in MnDHO, relative to the year before.

North Carolina

North Carolina launched an enhanced PCCM program in 1998 called Access II Care. The state created regional provider networks that employ nurse case managers to help coordinate care for the chronically ill. In addition to their FFS rates, network providers are reimbursed a small per member per month (PMPM) rate to adopt best practices and establish improvement goals. The state Medicaid agency employs case managers and has developed physician practice supports to improve processes. Enrollees in Access II Care have a variety of chronic conditions, the most prevalent being asthma, diabetes, and congestive heart failure, and, in some networks, ADHD and gastroenteritis. Preliminary findings in North Carolina suggest the Access II Care approach – a nurse case manager combined with a selective provider network – can lead to improved health outcomes for enrollees.

Indiana

Indiana began its PCCM program in 2003 as a jointly administered program between the Medicaid agency and the Department of Health. Americhoice, a national Medicaid managed care organization, is the PCCM administrator for the state. Members are stratified into a low severity or high severity group for care management. Low severity members access care management through a call-center and receive follow-up contact. High-severity members access care management through one-on-one intensive support and follow-up from nurse care managers. Those enrolled in the PCCM program are currently people with asthma, diabetes, and congestive heart failure. Indiana intends to expand the program in the future to people with hypertension, stroke, and HIV/AIDS. No data on cost savings or utilization changes are available at this time.

Florida

In 1999, the Florida legislature mandated the creation of disease management programs for Medicaid members with certain chronic conditions, including asthma, congestive heart failure, diabetes, hypertension, and HIV/AIDS. The Florida Medicaid agency, the Agency for Health Care Administration, entered into a risk-based contract with several vendors to administer the program. Vendors were expected to generate cost savings and improve health outcomes for the members. Approximately 20,000 members are enrolled in these disease management programs. An evaluation of the program in 2004 demonstrated an overall 2% reduction in inpatient stays, a 3% reduction in Emergency Department use, and a 1% reduction in office visits.

Lessons for Rhode Island

A recent analysis of state Medicaid programs enrolling adults with disabilities, conducted by the Center for Health Care Strategies[17] for the state of California, offers the following lessons for Rhode Island to consider as we develop our managed care options.

Building managed care for adults with disabilities takes time.

- Despite Rhode Island's extensive experience with RIte Care and Connect Care, creating a new model or building on an existing model will take time. Provider contracts, network development, and establishment of performance measures will need to be thoughtful and should deliberate.

States benefit from truly meaningful efforts to involve disability organizations, individual consumers, and family members in the design of their program.

- Consumer involvement and engagement is a guiding principle for DHS as we develop managed care for adults. Due to the increasing disenfranchisement of Medicaid adults with disabilities, this will be a difficult but extremely necessary goal to accomplish.

It is beneficial to design the most comprehensive managed care program possible for adults with disabilities (inclusive of some oral health care).

- Experience with the RIte Care program informs us that a comprehensive package of benefits, as opposed to several carve-outs, offers the most in terms of cost containment and improved health outcomes.

It is ill advised to pursue managed care with the sole goal of achieving short-term cost savings.

- Most states are able to obtain cost savings over time through better clinical management and care coordination. These savings are achieved after several years of program operation.

Building a competent and accessible provider network is an art, not a science.

- Developing an adequate provider network is the lynchpin in both Connect Care Choice and the Comprehensive Health Plan. Providers must be willing to take the extra time needed to participate actively in managing a member's chronic illness and/or disability and to attain the appropriate

[17] Highsmith, N. and Somers, S. Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States. September 2003.

level of "disability competency" in order to communicate with members effectively.

Care coordination for people with disabilities goes beyond the medical models of case management and disease management.

- It is common for a Medicaid client's psychosocial needs to be more profound than their medical needs. Therefore, it is important for managed care programs to support care management approaches that coordinate a member's behavioral health and social needs, in addition to providing clinical assessment.

Section 3.5 Opportunities For Collaboration With Statewide Improvements To The Health Care Delivery System

DHS is uniquely positioned to advance the managed care options for adults with disabilities in concert with a variety of statewide initiatives geared toward improving the delivery of health care in Rhode Island. There is a broad understanding that actionable health care change must be aligned with initiatives that are currently underway. There is a shared vision that Rhode Island needs to focus on creating a health care system that embodies the principles of consumer-focused, quality, coordinated care delivered in a community-based setting. Creative approaches are underway statewide to effect this change on an incremental basis. DHS seeks to collaborate with these initiatives and continue to build on the successes achieved to date.

The following information provides a brief description of several of these important statewide initiatives for building practice partnerships, establishing managed care programs in Rhode Island for elderly and disabled beneficiaries, and incorporating state and federal policy initiatives.

Building Practice Partnerships

Several efforts are underway in Rhode Island for designing collaborative practice partnerships. DHS seeks to partner with the initiatives listed below.

R.I. Chronic Care Collaborative

DHS recognizes the improved quality of chronic care offered through the R.I. Chronic Care Collaborative (RICCC), a grant-sponsored initiative under the Robert Wood Johnson Foundation's Improving Chronic Illness Care program. The RICCC is a joint initiative of the state's Diabetes Prevention and Control Program, Quality Partners of Rhode Island, Blue Cross Blue Shield, Neighborhood Health Plan of Rhode Island, and United Healthcare of New England. With 29 practices throughout Rhode Island participating, the mission of RICCC is to achieve excellence in practices by:

- Generating and documenting improved health outcome for people with diabetes
- Transforming clinical practice through models of care, improvement, and learning
- Developing infrastructure, expertise, and multi-disciplinary leadership to support and drive improved health status
- Building strategic partnerships
- Institutionalizing the chronic care models within a wide variety of practice settings

Allied Advocacy Group for Collaborative and Integrative Care

The Allied Advocacy Group (AAG) is a diverse group of Rhode Island health professionals, major health care payers, policy makers, educators, and consumers committed to integration of primary and behavioral (mental health, substance abuse, and behavioral medicine) health care into comprehensive care for the whole person. Such integration is seen as the necessary next step towards creating a well-functioning health care system. The AAG intends to serve as a mechanism for reducing constraints and supporting policies that facilitate collaborative and integrated care. DHS will seek to partner with these participants of this model of care.

Health Information Technology

The efforts underway as part of the Agency for Healthcare Research and Quality (AHRQ) R.I. Health Information Technology demonstration grant will support the development of the managed care programs for adults with disabilities. The creation of a Master Patient Index between public and private health care sectors will be an important feature in making patient information available for improved quality care in a timely, unduplicated fashion. This will allow the primary care physician, the specialists, and the Emergency Department physicians to have access to critical, up-to-date patient information on a 24-hour basis. Building on the statewide collaborative work accomplished by the R.I. Quality Partners and the Quality Institute, DHS will incorporate clinical information technology standards of health care improvements, including:

- Safety and measurement
- Technology infrastructure
- Knowledge-based care

Through program design, DHS will support these health information technology advancements to improve efficient access to accurate clinical data, whereby utilizing the best-known science in the delivery of health care and reducing preventable harm and errors.

Visiting Nurses Association (VNA) Legislative Grant

VNA Legislative Grant offers DHS an opportunity to partner with these agencies to promote managed care wellness initiatives.

Partnerships with Other Initiatives

DHS will issue a Request for Information (RFI) to solicit from the Rhode Island health care provider community innovative practice models to serve adults with disabilities. In addressing the complex medical needs of this population, DHS seeks to invite providers to offer innovative approaches that are consumer-focused, quality-driven, and cost-efficient. DHS would seek to execute contractual arrangements for the innovative practice models with a quality-driven performance reimbursement linked to demonstrated, evidence-based improved outcomes. The return on the investment with the innovative partnership would set forth program initiatives that reinvest the projected cost containment into maintaining wellness for the consumer in a less costly setting.

Establishing Managed Care Programs in Rhode Island for Elderly and Disabled Beneficiaries

Several managed care programs have been implemented recently for dual-eligible Medicare and Medicaid enrollees. DHS will monitor these programs carefully and build upon the successes gained through these initatives.

Program for All Inclusive Care for the Elderly (PACE)

PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized.

The BBA established the PACE model of care as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by DHS. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participant's needs, develops care plans, and delivers all services (including acute care services and when necessary and nursing facility services),

which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the interdisciplinary team for the care of the PACE participant.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.[18]

Rhode Island's first PACE demonstration site began enrollment December 1, 2005. PACE Organization of RI (PORI) was formed by CareLink, a network of community-based organizations providing care to seniors in Rhode Island. Enrollment as of March 2006 is 15.

Special Needs Plans

Under the Medicare Modernization Act of 2003, Congress created a new type of Medicare Advantage coordinated care plan called Special Needs Plans (SNPs) focused on individuals with special needs. "Special needs individuals" were identified by Congress as institutionalized, dually eligible, and/or individuals with severe or disabling chronic conditions. Congressional SNP authority expires in December 2008. This new authority allows Medicare Advantage plans that also have a SNP license to exclusively enroll dual-eligible beneficiaries.[19]

There are two Special Needs Plans in Rhode Island currently enrolling dually eligible. Optima, a new managed care product offered by Blue Cross/Blue Shield of RI in partnership with Neighborhood Health Plan of Rhode Island, was approved by CMS in September 2005, and began enrollment on January 1, 2006. Current enrollment is 1,565. Evercare is a SNP product of United Healthcare of New England with current enrollment of 850 people in nursing homes and 6 people in the community.

Incorporating State and Federal Policy Themes

The policy direction at the state and federal levels align closely with the legislative directive that guides our program proposal. DHS seeks to incorporate the themes from these policies into our program design.

[18] Source: Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/PACE/
[19] Source: Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/SpecialNeedsPlans/

The Governor's R.I. Health Policy Agenda

DHS voluntary managed care health care options will be informed by the Governor's Health Policy Agenda, which focuses on the following five goals:

- Wellness
- Balanced health care delivery system
- Anywhere, anytime health information
- Affordable small business insurance
- Smart public sector purchasing

Specifically, the proposed programs will incorporate the promotion of high quality chronic disease management in the primary care setting and a balanced redeployment of hospital-based service delivery. See Appendix G, Primary Care Innovative Guidelines. Additionally, the DHS programs will support and encourage access to electronic health information platforms. As a value-based purchasing agency, DHS will continue to build programs with health care partners committed to increasing access and quality care, while containing costs through contracted arrangements that delineate specific performance standards and measures.

Surgeon General Call to Action To Improve the Health and Wellness of People with Disabilities

On the federal level, the Surgeon General has identified four national goals for improving health and wellness of people with disabilities. These goals recommend increasing:

- Nationwide understanding that people with disabilities can lead long, healthy, and productive lives
- Knowledge among health care professional and providing them with tools to screen, diagnose, and treat the whole person with a disability with dignity
- Awareness among people with disabilities of the steps they can take to develop and maintain a healthy lifestyle
- Accessible health care and support services to promote independence for people with disabilities

The goals outlined in the Surgeon General's Call to Action emphasize the collective national effort needed to promote wellness and disease prevention for all people, including those with disabilities. With good health, people, with or without disabilities, can be gainfully employed and can be active and productive members of their community. These goals mirror the goals that DHS has for the managed care programs outlined in this report.

Section 4. Core Values and Guiding Principles for Medicaid Covered Health Care Services

Critical core values and guiding principles were used by the DHS team to design the voluntary managed care options presented in this report. Especially important was focusing on the specific needs related to the eligible population of Medicaid-only adults with disabilities currently living within the community.

Section 4.1 Core Values

Defining core values was a driving force in developing this plan. The recommendations presented in this report incorporate the core values of:

- Consumer-focused services
- A choice of health care delivery options
- A holistic approach to health care and wellness
- Independence in the community
- Access to primary and specialty care when and where needed
- Respect and dignity of the individual

Section 4.2 Guiding Principles

The guiding principles adopted for the development and design of the plans presented in this report were:

- Flexible options that match services with individual needs, both medical and social
- The establishment of a medical home that supports primary and preventive care
- A screening and assessment process that is coordinated and encompassing
- On-going involvement of critical stakeholders
- A focus on consumer self-management through education, community supports, and care coordination
- An evaluation process that successfully measures and reports outcomes, consumer satisfaction, service quality, and cost effectiveness
- Use of appropriate technology for coordinating and managing information and services
- Maximum, creative, and effective use of existing infrastructure
- Methods for ensuring cost predictability
- Responsible stewardship of public dollars

Section 5. Recommended Managed Care Options for Medicaid Adults with Disabilities

In accordance with the legislation H 5734 and S 0801 and using the feedback from interested stakeholders, DHS is proposing the following two voluntary managed care options:

- A primary care/nurse care management (PCCM) option, which offers a network of community health care providers
- A comprehensive health plan option, which offers a package of comprehensive benefits within a managed care structure.

Support services, which are especially critical to this population and enable these adults to continue to live within the community, will be "wrapped around" both options. To increase the likelihood of success with these initiatives, DHS will offer to the provider community resources available to meet the complex needs of this population. The core values and guiding principles, presented in a previous section of this report, are woven into each of the program designs.

In the following three sections, we will provide details of the eligible population within Rhode Island and will describe the two managed care programs being proposed. We believe these models, offered in a phased approach, will successfully meet the needs of this population and will satisfy the core requirements of the Rhode Island legislation.

Section 5.1 The Eligible Population

Adults with disabilities, the fastest growing segment of Rhode Island's population, currently receive health care services through traditional Fee-for-Service (FFS) Medicaid. The FFS model utilizes a greater amount of institutional-based health care. Medicaid is often fragmented, difficult to access, and not coordinated between consumer and providers. As highlighted in *A Vision for the Present and Future: Rethinking Chronic and Long Term Care in RI*, the number of people with a disability is growing and people with disabilities are living longer. Both realities are placing increasing demands on the existing medical care system. "While it may seem counter-intuitive to think in terms of prevention for people who already have multiple illnesses and conditions, avoidance of medical crises and forestalling functional decline will be essential to lowering health care costs and maintaining a reasonable quality of life for this population."[20] In responding to legislation focused on a program design for Medicaid-eligible adults with disabilities who are living in the community, DHS will seek to address the primary care and prevention and reduce barriers in order to enable this population to maintain wellness continue to reside in the community.

[20] A Vision for the Present and Future: Rethinking Chronic and Long Term Care in RI, by Susan M. Allen, PhD

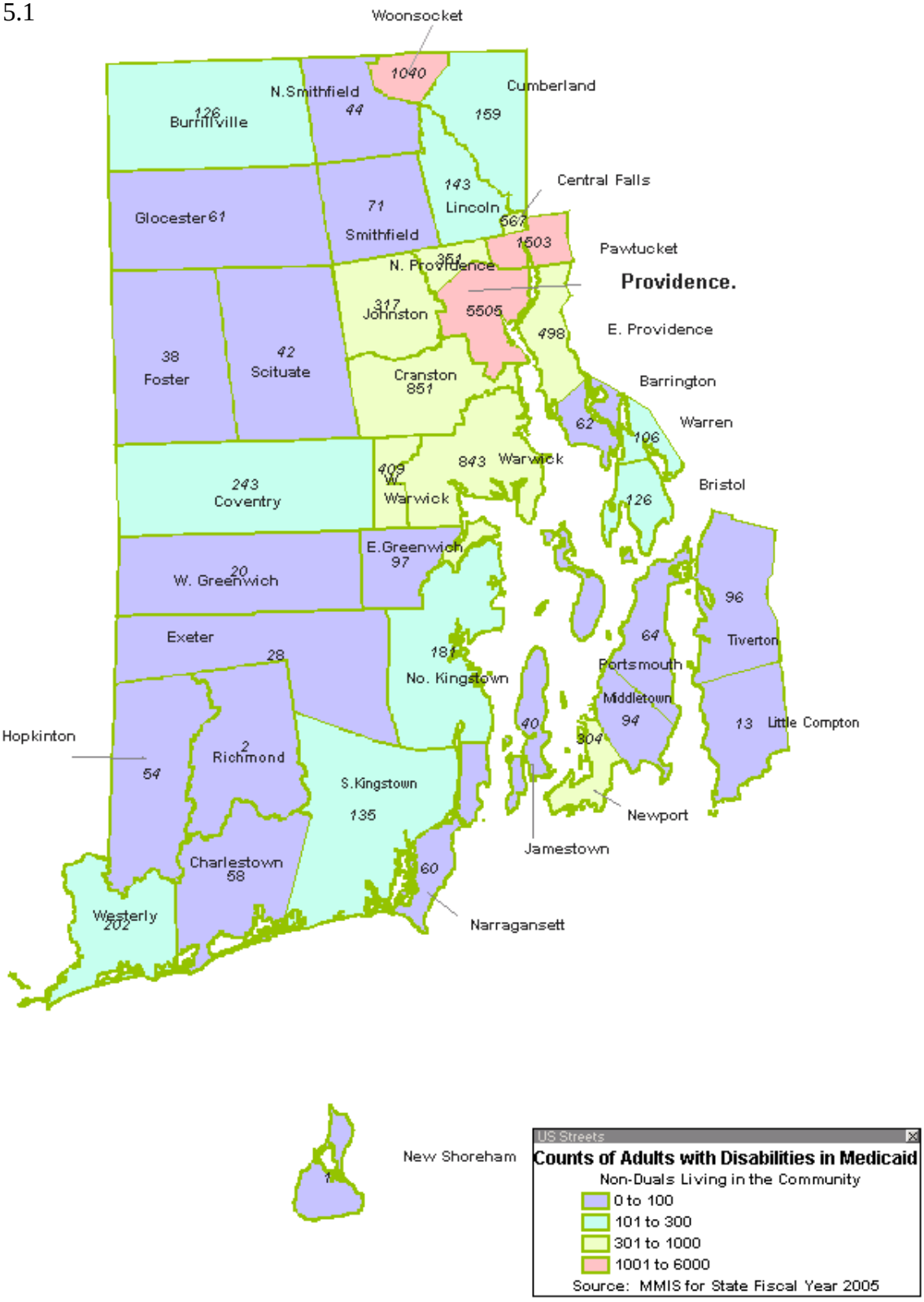
Recent experience from Medicaid Part D tells us that the enrollment and implementation process needs to be clear, well managed, and straightforward. To ensure a successful rollout of the two proposed plans, DHS is recommending a two-phased approach to enrollment. Phase One of the program will focus on adults aged 21-64 who are not institutionalized, do not have other third party coverage (including Medicare), and had fewer than 31 days in a nursing home within the year preceding enrollment. Phase Two of the program, dual-eligible adults with disabilities living in the community, will occur after the completion of Phase One.

Phase One

As previously stated, the Phase One population is adults with disabilities who are Medicaid-only eligible and are currently living in the community. The potential Phase One population eligible for managed care was 14,992 in SFY 2003 and 15,210 in SFY 2004. Trended forward, this population is estimated to be 1,500 in SFY 2006.

On the next page, Figure 5.1 provides a Rhode Island map, by municipality, showing the number of eligible enrollees residing within each community. DHS will use this information to ensure that available health care service delivery practices are included in the network of participating providers.

Figure 5.1


Woonsocket
1040
N.Smithfield
44
Cumberland
159
126
Burrillville
143
Central Falls
71
Lincoln
667
Glocester 61
Smithfield
1503
Pawtucket
361
N. Providence
Providence.
317
Johnston
5505
498
E. Providence
38
Foster
42
Scituate
Cranston
851
Barrington
62
106
Warren
409
W.
Warwick
843
Warwick
243
Coventry
126
Bristol
E.Greenwich
97
20
W. Greenwich
96
64
Tiverton
Exeter
28
181
No. Kingstown
Portsmouth
Middletown
94
13
Little Compton
Hopkinton
40
304
2
Richmond
54
S.Kingstown
135
Newport
Jamestown
Charlestown
58
60
Westerly
202
Narragansett
New Shoreham
1
US Streets
Counts of Adults with Disabilities in Medicaid
Non-Duals Living in the Community
0 to 100
101 to 300
301 to 1000
1001 to 6000
Source: MMIS for State Fiscal Year 2005

Expenditure Growth

The table below provides the Per Member Per Month (PMPM) cost for the Phase One population.[21]

Medicaid Only Adults with Disabilities living in the Community

	SFY 2003	SFY 2004	SFY 2005	Trend SFY 2006
Eligible Population	14,992	15,210	14,994	15,294
PMPM	$955	$1,057	$1,364	$1,500

Source MMIS Data extract March 2006

With this projected cost, it is critical that actionable measures be implemented to curb the expense while delivering high-quality, cost-efficient health care to this population. DHS will use quality-based purchasing initiatives combined with solid contractual performance standards to deliver comprehensive health care solutions within fiscal responsibility. Critical to this is the reinvestment of resulting savings back into the program options outlined later. The combination of stringent contract performance standards and improved health and wellness in a community-based setting will produce an improved delivery system while furnishing an accurate predictive cost modeling for this population. The implementation of these measures will impact the cost of long-term care in Rhode Island, as the collective goal of maintaining wellness and independence in a community setting will divert potential costs of long-term care.

Managed Care Solutions

Past experience from DHS initiatives with managed care programs, from managed care program implementation in other states, and from the recent efforts with Medicaid Part D shows that a successful implementation requires a well-organized, carefully planned enrollment process. We estimate the time required to develop and implement such a process for Rhode Island voluntary managed care program would be 18 months following the program's approval by the legislature.

The successful implementation of the two proposed managed care programs will require multiple strategies to address the needs of the populations. DHS will potentially reach out to the provider community via a Request For Information (RFI) to obtain innovative program models and to secure network capacity. Preliminary discussions with CMS indicate that DHS will need to seek federal authority for the managed care programs. Prior to rollout of the voluntary choices for this population, the following activities will be required:

- Procurement activities
- Development of the contract specifications
- Performance measurement and accountability

[21] Ibid

- Reimbursement methodologies and actuarial analysis
- Contracts with providers and health plans
- DHS systems modifications
- Federal authority application and approval
- Development of marketing and outreach materials
- Outreach and education of eligible population

As mentioned previously, the initial Phase One eligible population for the proposed programs would be adults, age 21-64, who are living in the community, who do not have other third party coverage (including Medicare), and who had fewer than 31 days in a nursing home within the year preceding enrollment. This eligible population is estimated to be approximately 15, 294 in 2006. To provide a process that is successful for these adults, we recommend that enrollment take place in the following three distinct stages:

Enrollment Stage One: Young adults transitioning out of RIte Care

To address an immediate need, the first enrollee population would be young adults currently in the RIte Care program who are transitioning to adulthood. There are approximately 150 young adults with special needs currently enrolled in RIte Care who "age-out" of the program each year when they reach 21 years of age. Currently, this group moves into traditional fee-for-service Medicaid. Once legislation is passed, these young adults would be offered continued enrollment in RIte Care and future enrollment into one of the new managed care options, as they were available. Enrollment of this population could begin on July 1, 2006.

Enrollment Stage Two: Adults with SSI parents

The second enrollee population would be the approximately 2,800 adults with disabilities who are Supplemental Security Income recipients whose families are enrolled in RIte Care. Because of their disability status, these parents are not currently offered enrollment in RIte Care with the rest of their family. This population would be offered the choice of enrolling in their family's RIte Care plan and would be offered future enrollment into one of the new managed care options, as they were available. Enrollment of this population could begin on January 1, 2007.

Enrollment Stage Three: Remaining eligible population

The third stage of enrollment would be for the remaining eligible population of Medicaid-only adults with disabilities. This group, approximately 15,210 people, would be offered enrollment in the new managed care options as each becomes available. Voluntary enrollment of this population could begin within 18 months of legislative directive.

Section 6 of this report provides details on the implementation and enrollment designs for each of the proposed managed care options.

Phase Two

Upon successful implementation of these programs for the Phase One eligible population identified earlier, DHS would develop and offer managed care options to the remaining population of adults with disabilities.

Section 5.2 Connect Care Choice

An expansion of Rhode Island's successful Connect Care program is proposed as one option for providing medical care to Medicaid-only adults with disabilities living within the community, the targeted eligible population. This program, to be called Connect Care Choice, will use an enhanced primary care/nurse case management model (PCCM) as the basis for the program's structure.

As described earlier, a basic PCCM model is a fee for service-based program where a primary care physician is paid a monthly case management fee to coordinate patient care. A PCCM model expands the traditional fee-for-service model by establishing a medical home for the beneficiary.

Rather than build or buy, Connect Care Choice will identify and "assemble" best practice sites of excellence into an enhanced preferred provider network. This quality-driven network of primary care practices will be coordinated with community-based nurse care managers and community supports to provide a statewide, sustainable health care delivery structure.

Connect Care Choice will also take advantage of existing statewide initiatives, such as the Rhode Island Chronic Care Collaborative, the Diabetes Control Program, and the Allied Advocacy Group for collaborative and integrative care for medical and behavioral health conditions. To create a coordinated, successful managed care program directly targeted to the needs of adults with disabilities, DHS envisions assembling a well-integrated system of medical care, social and health supports, and wellness initiatives that will improve the well being of the beneficiary and prove cost-effective to the state.

Connect Care Choice will be consumer-focused and will engage the consumers as active participants in their health care management, with the objective being improved over all health and continued independent living outside of an institutional setting. Additionally, Connect Care Choice will engage the provider community to be more responsive to the complex needs of this diverse, underserved population and to be more culturally sensitive to their issues.

Connect Care Choice—Specific Program Features

Connect Care Choice will incorporate three program components:

- Preferred Provider Network, for primary and preventive care
- Nurse Care Managers, aligned with physician practices, for care coordination and disease education
- Member Services, for risk assessments, enrollment, and linkage to community-based supports

Preferred Provider Networks

Providing access to primary and preventive care and to create a medical home will be an integral part of the Preferred Provider Network. Participating practices will focus on quality and will align with Connect Care Choice goals for chronic care management. In addition to primary and preventive care, the basic standards include:

- Behavioral health screening, especially for depression
- Use of the Nurse Care Manager network
- Chronic disease education and support
- Electronic medical records
- E-Prescribing
- Shared records with behavioral health services

The program will require a different set of reimbursement strategies in order to promote Connect Care Choice goals and to reinforce the use of services in an ambulatory setting, thus avoiding unnecessary care in the more costly hospital setting. Partial capitation on a PMPM basis will be provided through DHS.

Preferred provider practices will also have access to two supplemental partial capitation options for enhanced practices. The first option requires participation in a more rigorous chronic care model and/or co-locating medical and behavioral health services within a single setting. This option will include the 29 Rhode Island Chronic Care Collaborative practice sites that currently partner with the Diabetes Control Program through a Robert Wood Johnson Grant and the 11 practice sites that participate in co-location of behavioral health and primary care providers in integrated practice settings. The second partial capitation option will be available to practices that locate a nurse care manager at the practice site.

Using the experience of other states and the feedback received in Rhode Island stakeholder meetings, Connect Care Choice will incorporate a pay-for-performance strategy for physician reimbursement. Outcomes and measures will be modeled on the Pay for Performance Program being developed by Rhode Island health care insurers and CMS in partnership with the American Medical Association.

Nurse Care Management Network

Important to the success of the Connect Care Choice model is the development of a strong, integrated Nurse Care Management network. DHS will contract with community-based providers and agencies for these services. These care managers will provide:

- Comprehensive physiological and psychosocial assessments
- Coordination of patient care issues
- Ongoing monitoring, outreach, and support
- Partnership with primary care physicians, including care planning
- A link to community-based waiver programs and supports
- Disease education and self management supports

The level of compensation to nurse care management agencies/providers will be based on patient risk assessment and on the level of intensity of case management to be provided. DHS proposes this be a two-level PMPM rate system. The current Connect Care program NCM will continue to manage high intensity individuals at the current rate, while the moderate and low intensity NCM network will be developed and will be reimbursed at a different rate.

Member Services

A strong member services function is an integral part of Connect Care Choice. This support will be provided by the member services unit within the Center for Adult Health at DHS or will be contracted out. Services offered will be:

- Call Center
- Risk screening
- Outreach
- Enrollment
- Link to peer supports and community support groups
- Link to small-group, community-based patient education programs based on the Stanford Chronic Disease Model for Self-Management

Additional Benefits

In addition to the current covered benefits under Medicaid, the Connect Care Choice will provide preventative and educational services, including:

- Smoking cessation counseling and medications
- Nutritional evaluations and counseling by a certified nutritionist
- Diabetes education through R.I. certified diabetes outpatient educators

Section 5.3 Comprehensive Health Plan

The second managed care model available to Medicaid adults with disabilities is the Comprehensive Health Plan. Health plans offer a comprehensive package of medical and behavioral health benefits that are accessible, high quality, and focus on primary care, specialty care, and chronic condition management. The Comprehensive Health Plan will integrate primary, specialty, ancillary, acute, pharmacy, and behavioral health care in the benefit package, and will coordinate with long-term care services/providers. Enrollees are given a single point of contact and will be able to choose from an expanded network of primary care, specialty care, ancillary, and behavioral health providers. Health Plan staff will provide linkages between internal medical case management and behavioral health staff as well as linkages with external agencies that provide community supports. Specific benefit package will be determined as we move forward.

The Comprehensive Health Plan—Specific Program Features

The Comprehensive Health Plan model draws upon the successful experiences of the RIte Care program, but also realizes the difficulty in creating a "one-size-fits-all" approach to managed care for adults with disabilities. DHS can require certain program elements from contracted health plans and performance goals and incentives into the health plan contracts. A brief description of some of the fundamental health plan components is provided below.

Expanded Choice of Providers	Health plans serving adults with disabilities will need to create networks of providers who have experience working with people with multiple conditions and co-morbidities. In addition, there is an expectation that plans educate providers to be "disability competent", meaning they are trained in how to accommodate lifestyle differences and communicate respectfully to members with disabilities.
Care Management	Health plans have the ability to administer a comprehensive physiological and psychosocial assessment to each member upon enrollment to determine a member's intensity of needs. Depending on the type of need identified, members are assigned to clinicians or paraprofessionals to coordinate their care. These service coordinators work with the member to establish health-related goals as well as higher-level long-term goals.
Quality Improvement	Quality improvement activities and incentives will need to be embedded within Comprehensive Health Plan provider contracts. RIte Care health plans are contractually required to collect and report HEDIS

Quality Improvement	and CAHPS data to the state. RIte Care health plan financial incentives are awarded based on HEDIS scores. DHS has the option to require the health plans to analyze HEDIS data specific to enrolled adults with disabilities and will supplement HEDIS measures with additional performance measures. These measures will be developed in partnership with the health plans and may include indicators like preventable hospitalizations, maintaining functional status, etc.
Medical Home	Traditionally, health plan members are often required to select a Primary Care Physician (PCP). Instead of a gatekeeper role, this PCP can help to create a medical home. A medical home is an approach to providing health care in a high-quality and cost-effective manner. Members with a medical home receive all the care they need from someone they know and trust. Physicians and patients are partners in identifying and accessing all the medical and non-medical care a person needs.
Additional Benefits	In addition to the complete package of Medicaid-covered services, the Comprehensive Health Plan has the flexibility to offer enhanced services. These can include coordination of transportation and interpreter services, nutrition counseling, and alternative therapies.
Coordination with Community Supports	While long-term care services and supports are not an "in-plan" benefit[22], coordination with those agencies that provide those services and supports will be a requirement. Staff who function as service coordinators will have a vital role in facilitating communication among the member, the physician practice, and the community support agency.

The following section describes the proposed implementation of the voluntary managed care options for Phase One.

[22] Note: In-plan vs. out-of-plan benefits are further defined in Section 6

Section 6. Implementation Approaches For The Comprehensive Health Plan And Connect Care Choice

The following table summarizes the necessary program design features for DHS to consider when implementing both managed care approaches. There are some areas that overlap in their similarities, and others that are different in their requirements or approaches. A detailed narrative follows the table.

Program Design Feature	Connect Care Choice	Comprehensive Health Plan
Enrollment	Phased in Approach Voluntary	Phased in Approach Voluntary with an Opt-out
Federal Authority	State Plan Amendment	State Plan Amendment & 1915(b) waiver
Procurement, Contracting, and Certification Standards	Individual contracting with network providers	Competitive Bid for health plan contract
Payment Methodology	PMPM to physicians and nurse case managers	A working rate moving to a partial risk-based contract with risk adjusted rates to health plans
Systems Modifications	Small to moderate changes to MMIS and InRhodes	Changes to MMIS and InRhodes need further review
Cost Savings/Reinvestment	$1.4 million saving across both options	
Timeline	Group 1 - 2007 Group 2 - 2007 Group 3 - 2008	Group 1 - July 1, 2006 Group 2 – January 1, 2007 Group 3 – July 1, 2007

The Comprehensive Health Plan

Enrollment

The eligible populations for the Comprehensive Health Plan option are Medicaid-only adults, over age 21, living in the community (e.g. excluding nursing home residents and residents of psychiatric hospitals). There were approximately 15,210 eligible enrollees in SFY 2005. DHS recommends enrollment in the Comprehensive Health Plan to occur in phases.

Group 1: RIte Care Children Transitioning to Adulthood. There are approximately 150 children with special needs enrolled in RIte Care who "age-out" of the program each year. This will be the first group enrolled. Voluntary enrollment for this group could begin July 2006.

Group 2: SSI Parents. Currently there are 2,768 adult Supplemental Security Income (SSI) recipients whose families are enrolled in the RIte Care program. In an effort to create consistency in how a family receives health care, this will be

the second group enrolled. Voluntary enrollment for this group could begin January 2007.

RIte Care Health Plan	Number of SSI Adults with Enrolled Family
BlueCHiP	248
United Health Care	954
NHPRI	1,548
Unknown	18

Group 3: Community-Based Adults (those not in Group 1 or 2). All remaining eligible adults will comprise the third group enrolled in the program, by geographic region. Enrollment for this group could begin within 18 months of legislative directive.

Strategy for Voluntary Enrollment

The legislation, as it is written, directs DHS to create voluntary managed care options for adults with disabilities. An issue for the Comprehensive Health Plan is critical mass. Experiences from other states demonstrate that a voluntary program does not create the critical mass of enrollees necessary to sustain a program and generate cost containment. Medi-Cal, California's Medicaid managed care program, enrolls people with disabilities into health plans on both a mandatory and voluntary basis. In those counties where enrollment is voluntary, approximately 14% of beneficiaries choose to enroll[23]. Similarly, the Minnesota Disability Health Options program experiences monthly enrollment between 6 and 15 persons with disabilities[24]. Both Indiana and Washington experienced problems in their early experimentation with managed care for people with disabilities because voluntary enrollment created selection bias and insufficient enrollment[25].

DHS is exploring several enrollment options that would address the issues of critical mass for the potential health plan contractors, and also recognizes the difficulty in conducting outreach to the eligible population. One such approach is an all-in/opt-out approach to voluntary enrollment in the Comprehensive Health Plan for the eligible group. Opt-out enrollment would involve sending communication to eligible enrollees notifying them that if they do not make an active choice to return to fee-for-service Medicaid, they will be auto-assigned to a health plan. Some of the members that opt-out of the health plan back into FFS may be eligible for Connect Care Choice. Those members will be sent communication regarding Connect Care Choice. This enrollment approach will be effective for enrolling the SSI parents and the RIte Care beneficiaries

[23] California Health Care Foundation Issue Brief. Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems. August 2005

[24] Palsbo, P., Parker, P. and Duff, C. Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities. Center for Health Care Strategies Resource Paper. January 2004.

[25] Ibid.

transitioning to adulthood (Group 1 and Group 2).

The advantages of this enrollment approach for adults with disabilities include:

- Maximizing enrollment into comprehensive health plans
- Allowing enrollees to have the opportunity to experience the benefits of health plan enrollment and, yet, be able to exercise choice to disenroll at any point in time
- Reducing the potential risk of adverse selection for both the health plans and the state

The opt-out approach currently used to enroll children with special needs into RIte Care and has resulted in a 68% enrollment rate in the health plan. The Connect Care program also attempted in opt-out enrollment approach, but with limited success – 40 % of the eligible population was never reached despite several attempts.

It is anticipated that eligible enrollees, who are affiliated with one of the 40 practices in the Connect Care Choice network, would not receive this opt-out communication.

DHS will continue to explore a program enrollment approach that meets the needs of all stakeholders.

Federal Authority

Preliminary discussion with the Centers for Medicare and Medicaid Services (CMS) Regional Office[26] indicate that DHS will need to seek federal authority for the health plan option through a 1915b waiver. This type of waiver allows for the following program design features:

- One health plan contractor – It is impossible to predict at this juncture whether one or several health plans will be interested in contracting with DHS to enroll adults with disabilities or if more than one health plan will meet the state's contracting standards. The 1915b waiver allows DHS to waive "freedom of choice" and contract with one health plan if necessary.
- Limit the Eligible Population – Because our initial eligible population does not include all Medicaid eligible adults in Rhode Island, the state needs a 1915b waiver of "comparability".
- Offer additional benefits – The existing state plan does not include several benefits that we anticipate a health plan can offer. Under the provisions of the 1915b waiver, the state can fund additional benefits using program savings. These benefits will include disease education, health education, behavioral health from private practitioners, and non-hospital-based therapies (speech, physical, occupational).

[26] DHS staff met with CMS-RO representative on February 13, 2006.

- Mandatory Enrollment – While the proposed program is designed as voluntary, the 1915b waiver gives the state the option to enroll people with disabilities on a mandatory basis, if the state so chooses.

This type of waiver must demonstrate cost-effectiveness. DHS will project expenditures using a trend rate for waiver years 1 and 2. On a quarterly basis, the CMS regional office will compare our projections with our actual expenditures. If our projections appear to be incorrect, CMS will allow us to amend them. There is no fiscal penalty to the state if we do not meet cost-effectiveness.

An important aspect of the Comprehensive Health Plan is the ability to offer additional benefits that are not offered in fee-for-service Medicaid. However, funding these benefits through savings in other areas, as required by the 1915b waiver, is a risky proposition for the state. An alternative scenario is amending the Rhode Island Medicaid State Plan in tandem with submitting a 1915b waiver. There are two key provisions in the state's plan that would need to be amended.

1. *Add new categories of behavioral health practitioners to serve Medicaid beneficiaries*
   This amendment would allow direct reimbursement for a broader set of providers and would allow clients to see mid-level clinicians, including psychologists and social workers, without needing to go 5throught the CMHC.
2. *Allow non-hospital based rehabilitation therapy providers to serve Medicaid beneficiaries*
   The current R.I. State Plan only allows Medicaid reimbursement for rehabilitative therapies (i.e. speech, physical, and occupational) at hospital-based clinics and home care settings. An amendment would allow members to seek therapy at community-based rehabilitation centers, which are often more cost-effective.

With the appropriate R.I. State Plan amendments in place, the Comprehensive Health Plan could offer these services as part of the existing package of Medicaid covered services.

Procurement and Contracting

DHS intends to enter into an actuarially sound contract with one or more health plans for Medicaid adults with disabilities. Health Plans could be reimbursed monthly on a prepaid capitated basis at a PMPM rate negotiated by DHS and the contractor(s).

DHS will explore all possible scenarios, including the issuance of a Request for Proposals (RFP) as the procurement document for this initiative. The procurement document would outline several areas that would require bidder response, including experience with people with disabilities, care management capacity, and ability to create an adequate network of providers to serve this population and design the Certification Standards.

As a precursor to the official procurement, DHS could issue a Request for Information (RFI) to potential bidders. This RFI is beneficial for both parties because it allows the potential bidder to begin assembling a program, and it allows the state to get a sense of the willingness of current vendors to contract for this group of Medicaid beneficiaries.

The procurement process, combined with the waiver authority, allows DHS to select contractors who meet the Certification Standards that adequately demonstrate their ability to offer high quality care to enrollees, whether through one or multiple health plans. (See Appendix H for an outline of the Certification Standards used for the Early Intervention Program)

Payment Methodology

A variety of payment methodologies are being explored. Lessons from other states and from the RIte Care program demonstrate that risk-based arrangements with the appropriate risk corridors in place (e.g. stop-loss and "risk-share") create incentives for high quality and cost-effective health care. However, for health plans to accept financial risk for a population of enrollees who are chronically ill and/or disabled, the state must set rates that are risk-adjusted according to the population's health and functional status. Health-based risk adjustment is the process by which the health status of an enrolled population is taken into consideration when determining capitation rates or other at-risk payments. Risk adjustment methodologies currently being used by other state Medicaid programs are shown below[27].

Risk Adjustment Model	Description	State Examples
Chronic Illness and Disability Payment System (CDPS)	The CDPS characterizes individuals using up to 43 non-mutually exclusive groups that correspond to 18 body systems or specific illness or disability categories. The CPDS categories rely on about 2,400 of the 14,900 diagnosis codes in the ICD-9 CM classification system.	New Jersey Oregon Pennsylvania
Adjusted Clinical Groups (ACGs)	ACGs cluster ICD-9 codes into 34 diagnostic groups. Every ICD-9 code is individually mapped into a particular diagnosis group, so a person with multiple diagnoses could be assigned to multiple diagnosis groups.	Maryland
Hierarchical Co-Existing Condition System (HCCs)	HCCs characterize patients by a disease or body system hierarchy of however many coexisting conditions are present. The foundation of HCCs is 432 diagnostic groups that are designed to distinguish higher cost from lower cost conditions.	Employers
Diagnostic Cost Groups	This approach maps each ICD-9 code to a	Medicare

[27] Barclay, T. and Patterson, K. An Introduction to Diagnosis-Based Risk Adjusters. Milliman & Roberson, Inc. 1998.

(DCGs)	unique DCG diagnosis group, called DxGroups. The DxGroups are then ranked in average cost order from lowest to highest	

Accurate rate setting is critical to achieving health plan stability and profitability over time, leading to long-term program sustainability for adults with disabilities enrolled in health plans. DHS will require funding to obtain the services of an actuarial firm to research the appropriate risk-adjustment methodology as well as create actuarially sound rates for the health plans in accordance with the federal Balanced Budget Act of 1997.

Systems Modifications

DHS contracts with EDS as its fiscal intermediary and administrator of the Medicaid Management Information System (MMIS). The MMIS manages the enrollment portion of the RIte Care program and also pays claims for RIte Care out-of-plan benefits and all Medicaid claims for adults with disabilities. Several levels of system modifications will be needed to accommodate this delivery system change. DHS will meet with EDS during the planning process to formulate an estimate of both modification hours and costs associated with this project. DHS anticipates both to be significant.

DHS contracts with Northrop Grummond to administer InRhodes, the eligibility system for almost all state programs including Family Independence Program (FIP), food stamps, General Public Assistance (GPA), long-term care waivers, RIte Care, and Katie Beckett. Many adults with disabilities qualify for Medicaid because of their status as SSI recipients. Medicaid eligibility is automatic for SSI recipients, so these SSI adults do not apply for Medicaid at DHS field offices. The Social Security Administration (SSA) sends their Medicaid eligibility status to InRhodes on a periodic basis. InRhodes sends Medicaid eligibility information to MMIS on a nightly basis. It is unknown at this time whether any modifications to the InRhodes system will be needed to implement the Comprehensive Health Plan.

Health Plan Benefits

In this proposed design for the Comprehensive Health Plan, there are benefits that are considered “in-plan”, and those that are considered “out-of-plan”. Specific “in-plan” and “out-of-plan” benefits will be determined as the program design moves forward. For purposes of this report, the “in-plan” and “out-of-plan” benefits are described below. Generally speaking, the health plan would include the following services:

- Physician services (primary and specialty care)
- Ancillary services (laboratory, radiology, diagnostic)
- Emergency and Urgent Care Services
- Pharmaceuticals (prescription and over the counter)
- Inpatient hospitalizations and short-term Skilled Nursing Facility
- Outpatient hospital services
- Preventive dental care

- Short-term inpatient and outpatient behavioral health
- Home health services
- Hospice services
- Durable Medical Equipment
- Podiatry and Optometry

In the Comprehensive Health Plan model, some services remain in FFS and are considered "out-of-plan". These services are:

- Dental Care (other than preventive services)
- Nursing home stays greater than 30 days
- Long-term care supports/waiver services (e.g. personal care, homemaker, etc.)
- Long-term behavioral health treatment at CMHCs

Cost Savings

As evidence from other states suggests[28], it is unreasonable to expect significant cost savings in the first year of a managed care program. However, when assumptions regarding moderate program shifts are made, it is possible to see a reduction in percent trend increases and an overall reduction in program costs. DHS anticipates that these savings will be reinvested into the managed care programs.

If no changes to Medicaid fee-for-service were made, the rate of increase and program costs PMPM for the initial eligible population would be:

Note To Reader: Per the Medicaid Annual Report, the four-year total expense trend for adults with disabilities is 10.4%, including people with other types of insurance (TPL). The analysis of claims experience for the eligible population of 15,210 for the comprehensive health plan is showing a 15% average annual trend from 2003-2005 based on 'in-plan" services.

Eligible Population Fee-For-Service PMPM – Historical Experience (2003-2005) and Projections (2006-2009) – In-Plan Benefits Only

	SFY 03	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08	SFY 09
PMPM	$707.06	$770.60	$ 940.93	$1,088	$1,256	$1,454	$1,695
% Increase		8.99%	22.10%	15%	15%	16%	17%

Source: MMIS Data extract, March 2006

[28] Section 4.3 of this report.

To project the impact of managed care on the Medicaid budget, the following assumptions were made:

Increase over time in:

- Primary care visits, 12-15%
- Behavioral health office visits, 12-15%
- Specialty care visits, 12-15%
- Rates paid to PCPs, specialists, and behavioral health providers, 5-12%

Decrease over time in:

- Emergency Department (ED) visits, 4-6%
- Inpatient hospital days, 2-5%
- Procedures performed in a hospital setting, 3-5%
-

When these assumptions are taken into consideration, the following **in-plan** expenses are projected:

Managed Care PMPM Projections for Eligible Population, In-Plan Benefits Only

	SFY 05	SFY 06	SFY 07	SFY 08	SFY 09
PMPM	$ 940.93	$1088	$1,256	$1,386	$1,593
% Increase		15.6%	14%	10%	13%

Source: MMIS Data extract March 2006

The projected savings in SYF 2008 and SYF 2009 could be estimated at 2%- 3%, if at least one third of the eligible population was enrolled in the Comprehensive Health Plan. On the basis of these estimates, the growth in the expense trends would be reduced by 1% - 2%.

Savings can be achieved in SFY 2007 by enrolling age-out children with special needs and SSI parents (Groups 1 and 2). The estimated 2006 capitation rate paid to NHPRI for children with special needs is $959 PMPM. When this is compared to the FFS cost of $1,088, that is a savings of $129 PMPM, which translates to $459,756.00 saved by not "aging-out" children with special health care needs. Larger savings occur by enrolling SSI parents of RIte Care children. Considering inflation, a managed care PMPM for 2007 is estimated at $1103 and the FFS cost is estimated at $1256 PMPM (a difference of $153). If 37 percent of the eligible population chooses the health plan, there would be an estimated 515 average enrollees in SFY 2007. Given this enrollment, savings of $946,972 are possible in SFY 2007. Total estimated program savings possible in SFY 2007 for both eligible groups totals $1.4 Million.

A major assumption of this initiative is that costs and utilization will be shifted from higher cost less appropriate settings to less expensive and more appropriate settings. One area where this is evident is the decrease of emergency department visits that are projected in the second and third years of the program. In fiscal year 2007, the ED visit

rate is projected at 1,748 visits per 1,000. In fiscal years 2008 and 2009 (post managed care implementation), the projected ED visit rates are 1,678 and 1,611 visits per 1,000.

Timeline

The recent experience with implementation of Medicare Part D offers lessons for the implementation of the Comprehensive Health Plan for adults with disabilities. The eligible enrollees are often disconnected from society and difficult to locate. Health plans in other states report needing at least six months to create an adequate network of providers to serve this population[29]. Information systems modifications could take a year or more. For these reasons and several others, enrollment of all eligible groups will not be complete until late 2007.

Dual Eligibles

Medicare is federal health care program for the elderly and disabled created in 1965 by Title 18 of the Social Security Act. The primary pathways to Medicare eligibility are:

- People age 65 or older with employment history
- People under age 65 with certain disabilities and an employment history or disabled < age 21 under a parent with work history – this requires the presence of a disabling condition for 24 months. After 24 months, a person becomes eligible for Medicare
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare covers a different set of services than Medicaid, which can often create confusion for providers as well as clients when seeking health care. For Medicaid-only adults if their disability persists for greater than 24 months, they become eligible for Medicare. The person attaining 65 years of age drives another eligibility pathway to Medicare from Medicaid.

The first phases of enrollment in the Comprehensive Health Plan are focused on Medicaid-only adults; therefore dually eligibles will not be able to enroll in the Comprehensive Health Plan at this time. However, DHS recognizes that dually eligible members experience a fragmented health care delivery system and is committed to reducing this fragmentation and improving integration between Medicaid and Medicare for dually eligibles. In order to accomplish that, Rhode Island is reviewing a recent draft preliminary guidance from the Centers for Medicare and Medicaid Services (CMS) on this issue. This guidance presents several options for states to consider for integrating Medicare and Medicaid services. DHS continues to review this federal guidance and have not ruled out any options at this time.

[29] Highsmith, N. and Somers, S. Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States. Center for Health Care Strategies. September 2003.

Connect Care Choice

Implementation of Connect Care Choice will be based on strategic approach to "assembling" the program and will require a three-pronged approach:

- Identifying and contracting with primary care providers to create the enhanced preferred provider network
- Identifying and contracting with nurse care management providers for the nurse care management network
- Identifying, screening, and enrolling adult Medicaid recipients living in the community.

These implementation activities will occur in a phased in sequential manner.

Phase 1: The preferred provider networks, initially starting with the active enhanced primary care practice sites such as the 29 Rhode Island Chronic Care Collaborative practice sites and the 11 co-located behavioral health and primary care practice sites. These practices encompass all practice settings, including private group practices, federally qualified health centers and hospital-based ambulatory clinics.

Phase 2: The nurse care manager provider network will initially be identified on a geographical basis to partner with the preferred provider network development and will be contracted to provide nurse care management services to those practices that are contracted and participating.

Phase 3: The eligible population, 15,210 Medicaid-only adults, age 21 and older, living in the community, will be recruited and enrolled into this voluntary program by initially matching these members who are already connected to one of the contracted preferred provider networks. The primary care provider will have a significant role in encouraging their patients to voluntarily take advantage of the extra benefits and care management offered in this approach to chronic care management.

Preferred Provider Network	Number of Potential Adult Enrollees	Anticipated Enrollees	Enrollment Timeline
R.I. Chronic Care Collaborative	5,800	500	2007
Co-Located BH and Primary Care	450	64	2007
Networks to Be Developed to be determined	9,500 (Trend >5%)	5,700	2008-2010

Phase 4: The remaining adult population (TBD) will be enrolled into Connect Care Choice as new preferred provider networks and nurse care management providers are developed and contracted. The goal will be to identify primary care practices with large volumes of adult Medicaid only patients and work with those providers to achieve the enhanced practice standards necessary to participate. It is estimated that this will take 18 to 24 additional months.

DHS recognizes from previous experience that voluntary enrollment is both time and resource intensive. Strategies that work in other settings and populations do not work here. As discussed earlier in this report, Connect Care opt-out enrollment efforts provided a small return on investment and were very labor intensive. Of the total registered mailings, less than 70% of the targeted population actually received the mailing. Of these,

- 20% were contacted through DHS outreach efforts over 30 to 60 days
- 30% of those contacted enrolled
- 10% of those contacted refused to enroll

Additionally, 30% of those who received the mailing did not respond and could not be contacted, and 30% were unknown. Using an opt-out strategy for the Connect Care population resulted in only a 30% enrollment.

Experience from Connect Care shows that the most successful enrollment strategy for this population was achieved through an existing provider relationship or through a hospital-based nurse care manager working with discharge planners and the potential enrollee. This strategy is producing 12 to 15 enrollees per month. As additional preferred provider networks and nurse care managers are recruited, the enrollment numbers would increase accordingly, with an estimated 500 new enrollees by third quarter 2007.

Federal Authority

Preliminary discussions with a representative from the Centers for Medicare and Medicaid Services (CMS) Regional Office on February 13, 2006, indicated that a State Plan Amendment would allow for the preventive services and additional physician and nurse care management reimbursement. As well, the State Plan Amendment would allow for specific additional disease management services such as smoking cessation, nutrition counseling, and disease education, all integral components of Connect Care Choice. Also, because the program is voluntary and not restricted to a subset of the population, a waiver would not be required.

Additionally, there are two key provisions in the State Plan that will need to be amended to provide a comprehensive approach to chronic care management in this population, which has over 30% co-occurring behavioral health conditions and a significant need for expanded rehabilitative services. These provisions are:

- Allow community-based behavioral health practitioners to serve Medicaid beneficiaries. This amendment would provide reimbursement for a broader set of providers and would allow clients to see mid-level clinicians, including psychologists and social workers.
- Allow non-hospital based rehabilitation therapy providers to serve Medicaid beneficiaries. The current State Plan only allows Medicaid reimbursement for rehabilitative therapies, such as speech, physical, and occupational, at hospital-based clinics and home care settings. An amendment would allow members to seek therapy at community-based rehabilitation centers, which are often more cost-effective.

Procurement and Contracting

DDS's strategy for developing the network of primary care physician practices and nurse care managers for the Connect Care Choice model will include building upon the current infrastructure. The Rhode Island Chronic Care Collaborative practice sites and the co-located behavioral health and primary care practice sites will offer the initial network of preferred practice sites. Additional recruitment of providers will include identification of providers through analysis of claims encounter data and providers in the geographic location where enrollees reside. The nurse care manager provider network will be developed to compliment the participating provider sites.

In an effort to extend the opportunities to partner with practice sites, DHS will potentially issue a Request for Information (RFI) to solicit innovative practice models to compliment the Connect Care Choice managed care option. Potential information gleaned from the RFI process would be incorporated into the design of the standards.

Standards for participation, developed by DHS, will be used in contracting for the services. The participation standards be quality-driven and customer-focused, integrating preventative care evidence-based clinical guidelines that measure and monitor the delivery of services. Enhanced reimbursement methodologies, outlined below, will be tied to the performance specifications. Additionally, the network will be responsible for linkages to the community support services for the eligible population.

Financing

Connect Care Choice requires a per member per month (PMPM) payment to participating physicians and nurse care managers. This can be accomplished by either including the PMPM for the nurse care managers with the physician PMPM payment or by providing a separate payment either to the practice or through a contractual arrangement with a community-based nurse provider/agency. The PMPM will be a partial capitation to provide a financial incentive for attracting the participation of best practices and to offset the low reimbursement for fee-for-service Medicaid physician visits. The partial capitation will be designed as four rate cells, depending on the level of service provided—basic verses an enhanced, with or without a nurse care manager. These rates

will be comparable to current Connect Care physician reimbursement and to RIte Care average visit rate annualized.

The partial capitation cells will be as follows:

Preferred Provider Status	PMPM	Annual Total Increase Per Individual Enrolled
Range of PMPM	$25-$35	$300-$420
Basic	TBD	TBD
Basic with Nurse Care Manager	TBD	TBD
Enhanced	TBD	TBD
Enhanced with Nurse Care Manager	TBD	TBD

The design for Connect Care Choice also provides for contracting with community-based nursing agencies/providers for nurse care managers. This will result in an additional $5 PMPM for enrolled individual. With initial assessments and disease education being conducted in an at-home setting, we are also anticipating an increase of $63 per visit. The annual increase per individual enrolled will be, on average, $250.

It is estimated that the initial enrollment of 500 new enrollees into Connect Care Choice will cost an additional $430,000 for fiscal 2007.

Program Component	Additional PMPM	Total Enrollees	Projected Annual Cost
Physician	Average of $30	500 x $360	$180,000
Nurse Care Manager	$5 + 3 visits @$63 per visit	500 x $250	$125,000
Member Services FTE			$125,000
Total Cost			**$430,000**

Accurate and fair reimbursement to providers is essential to recruiting and enrolling practices that provide enhanced chronic care management and preventative services. The above-suggested partial capitation rates are based on the PCCM model "Sooner Care Choice" in Oklahoma and on feedback from the R.I. physician community.

Our experience with Connect Care and the experience of other states in enrolling adults into managed care programs indicate a real opportunity to offset unnecessary care in the most costly in-patient setting, while increasing primary and preventive visits in the community.

Systems Modifications

Connect Care Choice will require system modifications for both the MMIS and InRhodes systems. Both the physician partial capitation PMPM and the nurse care manager PMPM will require a monthly capitation to be paid for each member enrolled, which must be linked to these providers. There also needs to be a flag in the eligibility screens/system that identifies these individuals as participating in Connect Care Choice and identifies the physician provider and the nurse care manager. DHS has had some experience in this type of programming through the implementation of Connect Care and the PACE program.

Section 7. Conclusions

The legislation H 5734 and S0801 presents the department with an exciting opportunity to improve the health care delivery system for adults with disabilities in Rhode Island. The report outlines the department's proposal for voluntary managed care options for adults with disabilities that:

- Integrates an efficient financing mechanism with quality service delivery;
- Provides a medical home to assure appropriate care and deter unnecessary and inappropriate care; and
- Places an emphasis on preventive and primary care.

DHS is proposing a two voluntary managed care model options that encompass a phased-in approach choice for Medicaid-only adults with disabilities living in the community. The Connect Care Choice and the Comprehensive Health Plan, enhanced by the community support "wrap around," are offered as health care delivery system options. The managed care options will meet the complex medical needs of this population by reducing barriers to care and creating opportunities for improved quality of life in the community.

The development of the voluntary managed care options seeks to address the following:

Challenges	Opportunity
Complexity of the beneficiaries and the system	Create a medical home to coordinate complex medical needs of beneficiaries and provide linkages to necessary supports in the community
Access to care	Expand network of providers through improved performance reimbursement and practice supports and education
Increased Cost trends with high institutional concentration	Curb cost trend increases by moving care to less expensive settings in the community with an emphasis on preventive and primary care
Quality and Accountability	Value-based purchasing contractually tied to performance standards and monitored quality, evidence-based clinical measures and outcomes

The momentum for changing the current FFS delivery system is combined with a renewed emphasis on developing a statewide strategic vision for chronic and long-term care services, innovative practice redesigns, and health information technology. DHS may convene an Advisory Committee to guide in the implementation of the program options and assist in communications with the public.

The eligible population had expenditures of almost $193 million in SFY 2004. Opportunities exist for action to curb the growth trends and provide appropriate health care service for this vulnerable population through managed care programs. The proposed options offer an investment in providing flexible health care options that improve the quality of life in the community and divert care from costly institutional settings. The current spending for this population with inflation trended forward is illustrated below.

Eligible population Fee-For-Service PMPM – Historical Experience (2003-2005) and Projections (2006-2009) – In-Plan Benefits Only

	SFY 03	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08	SFY 09
PMPM	$707.06	$770.60	$ 940.93	$1,088	$1,256	$1,454	$1,695
% Increase		8.99%	22.10%	15%	15%	16%	17%

Source: MMIS Data extract March 2006

With the implementation of the managed care options, the projected saving in SYF 2008 and SYF 2009 could be estimated between 2%- 3%. On the basis of these estimates, the expense trend growth would be reduced by 1% - 2% to approximately 15%, yielding a measure of budget predictability.

If the future savings are to be realized, the programs outlined in this report will require budget initiatives to fund integral components of the designed managed care options. The department is seeking guidance from the legislature on several key elements of the program design and necessary budgetary support.

Voluntary versus Mandatory Enrollment

The confounding variable in developing this recommendation is the issue of voluntary enrollment versus mandatory enrollment. The legislation instructs DHS to develop voluntary managed care options for adults with disabilities. Currently, DHS does not have federal authority to conduct mandatory enrollment for this population. Therefore, the report proposes voluntary opt-out enrollment into the Comprehensive Health Plan model that would balance the need to achieve critical mass while preserving consumer choice.

DHS recommends the opt-out approach for voluntary enrollment into the Comprehensive Health Plan for the RIte Care Children with Special Health Care Needs Transitioning to Adulthood and SSI Parents (Group 1 and Group 2).

DHS is exploring several enrollment options that would address the issues discussed relating to mandatory enrollment versus voluntary enrollment to achieve critical mass needed for the Comprehensive Health Plan and avoiding adverse selection of the Connect Care Choice model. The area needing further discussion is identifying the selection criteria for mandatory enrollment into either the Connect Care Choice or the Comprehensive Health Plan.

Legislative action would be necessary to change the 2005 legislation to a mandatory enrollment process.

Areas of Legislative Support needed:

DHS will need additional resources to build the infrastructure to support the operation of the voluntary Connect Care Choice option. Cost assumptions from projected program savings will be reinvested to support the additional resources.

Provider reimbursement increases are necessary in both voluntary models. Cost assumptions from projected program savings will be reinvested to support the enhanced reimbursement to the providers.

Voluntary choice of the options presents challenges in achieving critical mass of enrollment under the health plan model. The opt-out proposal for voluntary enrollment with safe guards built into the design should support voluntary enrollment. Reinvestment of saving from the health plan option would allow this option expand the benefit offering, such as Oral Health.

Achieving critical mass of enrollment is not an issue with the Connect Care Choice model. Upon meeting participation standards, reinvestment of savings in the Connect Care Choice model would support continued enhanced payments to the providers and promotes additional practice enhancement.

Final Thoughts

DHS looks forward to direction from the legislature on the department's proposal for voluntary managed care options for adults with disabilities living in the community.

With clear opportunity for improvements in the delivery of health care services for this population, DHS is positioned to take action on implementing these options. The environment for changing the current system through programs designed to improve quality of life and effectively use resources, benefits both the beneficiaries that use the services and the public dollars that support the services.

APPENDICES

A. List of Community Forums and Presentations
B. List of Issues Raised at Community Forums
C. H5734/S0801 Legislative Text
D. Home and Community-Based Waiver Description
E. Connect Care Program Outcome Measures
F. Connect Care Program Clinical Outcome Measures for Cohort (N=45) at one year in program
G. Primary Care Innovative Guidelines Draft
H. Certification Standards Outline Early Intervention September 2005
I. DHS Project Team

APPENDIX A. LIST OF COMMUNITY FOURMS AND PRESENTATIONS

Presentation	Date	Attendance
DHS Management Roundtable	05/17/05	Not Available
Consumer Advisory Committee	06/30/05	Not Available
DHS Senior Management Meeting	07/06/05	Not Available
Real Choices Community Conference	09/27/05	Not Available
Cross-agency Managed Care Work Group	09/28/05	12
Advocates in Action	10/27/05	25
Community Mental Health Association	11/04/05	15
Mental Health Medical Directors	11/07/05	12
Community Forum Cranston	12/01/05	11
RI Collation of Mental Health Administrators	12/01/05	20
Community Forum Pawtucket	12/05/05	18
Mental Health Medical Directors	12/05/05	12
Community Forum Middletown	12/08/05	9
Community Forum South County	12/12/05	6
Hospital Association of RI	01/09/06	8
Lifespan	01/12/06	11
Rhodes To Independence	01/17/06	15
RI Developmental Disabilities Council	01/18/06	23
RI Primary Care Advisory Committee	01/18/06	21
Sherlock Center Board Meeting	01/25/06	16
Independence House Residence	01/26/06	8
RI Medical Society	01/27/06	6
Lifespan	02/01/06	8
Elmhurst Independent Living Residence	02/02/06	12
CMS Regional Staff	02/13/06	9
RI Community Health Centers Board of Directors	02/16/06	12
RI Community Health Centers Medical Directors Society	03/16/06	8

APPENDIX B. LIST OF ISSUSES RAISED AT COMMUNITY FOURMS AND PRESENTATIONS

Topic	Discussion
Benefits	• Glasses w/ Tint coverage • False Teeth, dentures covered one set every 5 years • Crowns/caps coverage • Eligibility requirements for Disabled Adult condo owner relaxed • Hearing aid coverage - only 1 covered member paid $600 out of pocket • PT/OT/SP increased visits • Aqua Therapy coverage and setting • Medicare coverage of out of state provider • New wheelchair, over five years old • Chiropractic/massage therapy • Podiatry benefit limit between appointment shorter than 9 weeks • Personal Care attendants coverage Buddy System • When taking Rx that effect the mouth, increase dental visits • GYN/PAP yearly • Transportation for sick visit • Delivery of authorized DME equipment
Behavioral Health	• Better communication between PCP and Behavioral Health Provider regarding Rx to avoid adverse drug interaction • Private practitioners can pick and choose the service deliver array • Reimbursement rates should be skewed for CHMC that provide the full array of services • Access to practitioners for non-SPMI services
SPMI	• CHMC will see consumer during the crisis and then have appointment availability for next day. Private practice does not afford same service • If SPMI is carved out, need to address how SPMI crossover services will be delivered • Carve out SPMI
PCP Linkages	• Better communication between PCP and Behavioral Health Provider regarding Rx to avoid adverse drug interaction • Request for consideration of funding of telephone consults with PCPs on patient management if the goal is to improve collaboration between PCPs and BH Licensed Independent Practitioners. • Linkages with Community Supports • Information on my disability

Topic	Discussion
Network	• Psychiatrists not take Medicare/Medicaid, pay out of pocket • Expansion of behavioral services will create a capacity issue for the CMHCs • Often times Psychiatrist are listed as participating in the network, but in fact are closed • Wait lists for services will increase if capacity is not addressed • Culturally sensitivity to adults with disabilities • Transition issues from Pediatric practice to Adult practice
AHCRQ initiative exclusion	• AHCRQ initiative, CMHC participation not addressed…issues regarding privacy • Build on medical practice technology
Cost	• Cost will increase, not decrease • Enhanced provider payments
PCP Feedback	• Parity in reimbursement with other payers should reflect the complexity of the care needs of disabled recipients. • Attempts should be made to identify core groups of providers with expertise in complex patients. This should not discourage providers who wish to obtain expertise in caring for this patient group. • Programs should allow for flexibility in delivery of care to allow for innovation. • Care managers are generally good idea and could be employed in a practice or as a partnership with an outside agency such as nursing agencies. • Specific standards for participation should be established that include access and practice structure. • Pay for performance is useful if standards are evidence based and can be measured reliably. It is a way for the system to drive change towards improvement. • A strong connection between primary care and mental health providers is essential. • We should look to these successes of current programs including Rite Care, Connect Care and some of the successful programs at MHRH that include case management and medication management

APPENDIX C: H5734/S0801 LEGISLATIVE TEXT

S0801
Chapter 351
2005 -- S 0801 SUBSTITUTE A
Enacted 07/19/05

A N A C T
RELATING TO HEALTH CARE FOR ELDERLY AND DISABLED RESIDENTS

Introduced By: Senators Paiva-Weed, Gibbs, Alves, and Roberts
Date Introduced: February 17, 2005

It is enacted by the General Assembly as follows:

SECTION 1. Section 40-8.5-1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

40-8.5-1. Categorically needy medical assistance coverage. – (a) The department of human services is hereby authorized and directed to amend its Title XIX state plan to provide for categorically needy medical assistance coverage as permitted pursuant to Title XIX of the Social Security Act [42 U.S.C. section 1396 et seq.] as amended to individuals who are sixty-five (65) years or older or are disabled (as determined under section 1614(a)(3)) of the Social Security Act [42 U.S.C. section 1382c(a)(3)] as amended whose income does not exceed one hundred percent (100%) of the federal poverty level (as revised annually) applicable to the individual's family size, and whose resources do not exceed four thousand dollars ($4,000) per individual, or six thousand dollars ($6,000) per couple. The department shall provide medical assistance coverage to such elderly or disabled persons in the same amount, duration and scope as provided to other categorically needy persons under the state's Title XIX state plan.

(b) In order to ensure that individuals with disabilities, have access to quality and affordable health care, the department is authorized to plan and to implement a system of health care delivery through a voluntary managed care health system for such individuals. "Managed care"
is defined as a system that: integrates an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care.

(c) The department is authorized to obtain any approval and/or waivers from the United States Department of Health and Human Services, necessary to implement a voluntary managed health care delivery system to the extent approved by the United States department of health and human services.

(d) The department shall submit a report to the Permanent Joint Committee on Health Care Oversight no later than April 1, 2006 that proposes an implementation plan for this voluntary program, based on beginning enrollment not sooner than July 1, 2006. The report will describe projected program costs and savings, the outreach strategy to be employed to educate the potentially eligible populations, the enrollment plan, and an implementation schedule.

SECTION 2. Section 40-8.7-7 of the General Laws in Chapter 40-8.7 entitled "Health Care Assistance for Working People With Disabilities" is hereby amended to read as follows:

40-8.7-7. Premiums and cost sharing. -- (a) The department of humans services is authorized and directed to promulgate such rules to establish the monthly premium payments for employed individuals with disabilities who opt to participate directly in the Medicaid buy-in program. To participate in the Medicaid buy-in program, the employed individual with disabilities shall be required to make payment for coverage in accordance with a monthly payment or payment formula to be established by the department which shall count the individual's monthly-unearned income in excess of the medically needy income limit [MNIL] and shall count a portion of their earned income on a sliding scale basis, in accordance with rules to be established by the department;

(b) The department is further authorized and directed to promulgate such rules to encourage businesses, especially small businesses to hire individuals with disabilities, and to allow employed individuals with disabilities who have access to employer-based health insurance and who are determined eligible by the department pursuant to this chapter, to ~~either:~~ determine the optimal health insurance coverage in consultation with the employer and the Medicaid agency.

~~(1) Enroll themselves and/or their family in the employer-based health insurance plan as a condition of participation in the Medicaid buy-in program under this chapter, provided this also complies with the requirements of chapters 5.1, 8.1, 8.4 and 8.5 of this title, chapters 12, 12.1, 12.2 and 12.3 of title 42 as they relate to eligibility for the medical assistance program; and provided, further, that enrollment in the employer-based health insurance plan is cost-effective and its benefits are comparable to the benefits provided by the Medicaid program; or~~

~~(2) Enroll in the RI Medicaid buy-in program with employer/employee premium payments for coverage under the medicaid buy-in program; provided, that these premium payments are not greater than the employer's and employee's premiums in the existing employer-based health insurance.~~

SECTION 3. Section 40.1-24-1 of the General Laws in Chapter 40.1-24 entitled "Licensing of Facilities and Programs for People who are Mentally Ill and/or Developmentally Disabled" is hereby amended to read as follows:

40.1-24-1. Definitions. -- As used in this chapter:

(1) "Adult foster home" means a private family living arrangement which, through financial support from the parent deinstitutionalization subsidy aid program, provides housing and supervision to two (2) or more adults who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or otherwise eligible under section 40.1-1-10.1. Foster homes serving fewer than two (2) adults, foster home situations wherein the foster parents are natural or adoptive parent(s) or grandparents, and any facility licensed by the department of children, youth, and families shall be excluded for the purposes of this chapter.

(2) "Community residence" means any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least twenty-four (24) hours, where, on a twenty-four (24) hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three (3) or more persons who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury. The facilities shall include but not be limited to group homes, halfway houses, and fully supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs shall not be considered community residences for the purposes of this chapter.

(3) "Day treatment program" means any nonresidential facility which is established, offered, maintained, conducted, managed, or operated by any person for a period of less than

twenty-four (24) hours to provide therapeutic intervention to persons who are alcoholic, drug abusers, mentally ill, or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to outpatient programs for persons who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury.

(4) "Department" means the department of mental health, retardation and hospitals.

(5) "Facility" means any community residence, day treatment program, rehabilitation program, public or private, excluding hospitals or units within hospitals for persons who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury providing program services which do not constitute medical or custodial care, but do offer rehabilitation, habilitation, psychological support, and social guidance.

(6) "Habilitation program" means any nonresidential facility which is established, offered, maintained, conducted, managed, or operated by any person for a period of less than twenty-four (24) hours to provide training in basic daily living skills and developmental activities, prevocational skills and/or vocational training and placement, and follow up for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to early intervention, adult development, work activities, sheltered workshops, advanced workshops, and job development and training programs. Sheltered workshops not exclusively for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury shall be excluded for the purposes of this chapter.

(7) "Person" means any individual, governmental unit, corporation, company, association, or joint stock association and the legal successor thereof.

(8) "Program" means a planned service delivery system structured to provide specific components which are responsive to the needs of those served.

(9) "Rehabilitation program" means any facility which is established, offered, maintained, conducted, managed, or operated by any person to provide restorative therapy and/or training to persons who are mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to community mental health centers. Sheltered workshops not exclusively for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury shall be excluded for the purposes of this chapter.

40.1-24-2. Purpose. – (a) The purpose of this chapter is to provide for the development, establishment, and enforcement of standards:

(1) For facilities and programs providing rehabilitation, psychological support, and social guidance to individuals who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury;

(2) For the construction, maintenance, and operation of facilities which will promote safe and adequate accommodations for individuals who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury; and

(3) For the establishment of a comprehensive licensing policy with respect to facilities and programs for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury.

(b) The department of mental health retardation and hospitals is hereby authorized and directed to be the licensing authority in Rhode Island for residential and other support programs designed specifically for persons with cognitive disabilities such as brain injury. These licensure requirements shall be the same standards for persons with developmental disabilities except that for these purposes all references to "developmental disabilities" shall mean "cognitive disabilities."

SECTION 4. This act shall take effect upon passage.
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LC01888/SUB A

H5734

Chapter 394
2005 -- H 5734 SUBSTITUTE A
Enacted 07/19/05

A N A C T
RELATING TO HUMAN SERVICES -- HEALTH CARE FOR ELDERLY AND DISABLED RESIDENTS ACT

Introduced By: Representatives Naughton, Ajello, McNamara, E Coderre, and Dennigan
Date Introduced: February 17, 2005

It is enacted by the General Assembly as follows:

SECTION 1. Section 40-8.5-1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

40-8.5-1. Categorically needy medical assistance coverage. – (a) The department of human services is hereby authorized and directed to amend its Title XIX state plan to provide for categorically needy medical assistance coverage as permitted pursuant to Title XIX of the Social Security Act [42 U.S.C. section 1396 et seq.] as amended to individuals who are sixty-five (65) years or older or are disabled (as determined under section 1614(a)(3)) of the Social Security Act [42 U.S.C. section 1382c(a)(3)] as amended whose income does not exceed one hundred percent (100%) of the federal poverty level (as revised annually) applicable to the individual's family size, and whose resources do not exceed four thousand dollars ($4,000) per individual, or six thousand dollars ($6,000) per couple. The department shall provide medical assistance coverage to such elderly or disabled persons in the same amount, duration and scope as provided to other categorically needy persons under the state's Title XIX state plan.

(b) In order to ensure that individuals with disabilities, have access to quality and affordable health care, the department is authorized to plan and to implement a system of health care delivery through a voluntary managed care health system for such individuals. "Managed care"
is defined as a system that: integrates an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care.

(c) The department is authorized to obtain any approval and/or waivers from the United States Department of Health and Human Services, necessary to implement a voluntary managed health care delivery system to the extent approved by the United States Department of Health and Human Services.

(d) The department shall submit a report to the Permanent Joint Committee on Health

Care Oversight no later than April 1, 2006 that proposes an implementation plan for this voluntary program, based on beginning enrollment not sooner than July 1, 2006. The report will describe projected program costs and savings, the outreach strategy to be employed to educate the potentially eligible populations, the enrollment plan, and an implementation schedule.

SECTION 2. Section 40-8.7-7 of the General Laws in Chapter 40-8.7 entitled "Health Care Assistance for Working People With Disabilities" is hereby amended to read as follows:

40-8.7-7. Premiums and cost sharing. -- (a) The department of humans services is authorized and directed to promulgate such rules to establish the monthly premium payments for employed individuals with disabilities who opt to participate directly in the Medicaid buy-in program. To participate in the Medicaid buy-in program, the employed individual with disabilities shall be required to make payment for coverage in accordance with a monthly payment or payment formula to be established by the department which shall count the individual's monthly-unearned income in excess of the medically needy income limit [MNIL] and shall count a portion of their earned income on a sliding scale basis, in accordance with rules to be established by the department;

(b) The department is further authorized and directed to promulgate such rules to encourage businesses, especially small businesses to hire individuals with disabilities, and to allow employed individuals with disabilities who have access to employer-based health insurance and who are determined eligible by the department pursuant to this chapter, to ~~either:~~ determine the optimal health insurance coverage in consultation with the employer and the Medicaid agency.

~~(1) Enroll themselves and/or their family in the employer-based health insurance plan as a condition of participation in the Medicaid buy-in program under this chapter, provided this also complies with the requirements of chapters 5.1, 8.1, 8.4 and 8.5 of this title, chapters 12, 12.1, 12.2 and 12.3 of title 42 as they relate to eligibility for the medical assistance program; and provided, further, that enrollment in the employer-based health insurance plan is cost-effective and its benefits are comparable to the benefits provided by the Medicaid program; or~~

~~(2) Enroll in the RI Medicaid buy-in program with employer/employee premium payments for coverage under the medicaid buy-in program; provided, that these premium payments are not greater than the employer's and employee's premiums in the existing employer-based health insurance.~~

SECTION 3. Section 40.1-24-1 of the General Laws in Chapter 40.1-24 entitled "Licensing of Facilities and Programs for People who are Mentally Ill and/or Developmentally Disabled" is hereby amended to read as follows:

40.1-24-1. Definitions. -- As used in this chapter:

(1) "Adult foster home" means a private family living arrangement which, through financial support from the parent deinstitutionalization subsidy aid program, provides housing and supervision to two (2) or more adults who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or otherwise eligible under section 40.1-1-10.1. Foster homes serving fewer than two (2) adults, foster home situations wherein the foster parents are natural or adoptive parent(s) or grandparents, and any facility licensed by the department of children, youth, and families shall be excluded for the purposes of this chapter.

(2) "Community residence" means any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least twenty-four (24) hours, where, on a twenty-four (24) hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three (3) or more persons who are alcoholic, drug abusers, mentally ill

or who are persons with developmental disabilities or cognitive disabilities such as brain injury. The facilities shall include but not be limited to group homes, halfway houses, and fully supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs shall not be considered community residences for the purposes of this chapter.

(3) "Day treatment program" means any nonresidential facility which is established, offered, maintained, conducted, managed, or operated by any person for a period of less than twenty-four (24) hours to provide therapeutic intervention to persons who are alcoholic, drug abusers, mentally ill, or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to outpatient programs for persons who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury.

(4) "Department" means the department of mental health, retardation and hospitals.

(5) "Facility" means any community residence, day treatment program, rehabilitation program, public or private, excluding hospitals or units within hospitals for persons who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury providing program services which do not constitute medical or custodial care, but do offer rehabilitation, habilitation, psychological support, and social guidance.

(6) "Habilitation program" means any nonresidential facility which is established, offered, maintained, conducted, managed, or operated by any person for a period of less than twenty-four (24) hours to provide training in basic daily living skills and developmental activities, prevocational skills and/or vocational training and placement, and follow up for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to early intervention, adult development, work activities, sheltered workshops, advanced workshops, and job development and training programs. Sheltered workshops not exclusively for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury shall be excluded for the purposes of this chapter.

(7) "Person" means any individual, governmental unit, corporation, company, association, or joint stock association and the legal successor thereof.

(8) "Program" means a planned service delivery system structured to provide specific components which are responsive to the needs of those served.

(9) "Rehabilitation program" means any facility which is established, offered, maintained, conducted, managed, or operated by any person to provide restorative therapy and/or training to persons who are mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury. These shall include but not be limited to community mental health centers. Sheltered workshops not exclusively for people who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury shall be excluded for the purposes of this chapter.

40.1-24-2. Purpose. – (a) The purpose of this chapter is to provide for the development, establishment, and enforcement of standards:

(1) For facilities and programs providing rehabilitation, psychological support, and social guidance to individuals who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury;

(2) For the construction, maintenance, and operation of facilities which will promote safe and adequate accommodations for individuals who are alcoholic, drug abusers, mentally ill or who are persons with developmental disabilities or cognitive disabilities such as brain injury; and

(3) For the establishment of a comprehensive licensing policy with respect to facilities and programs for people who are alcoholic, drug abusers, mentally ill or who are persons with

developmental disabilities or cognitive disabilities such as brain injury.

(b) The department of mental health retardation and hospitals is hereby authorized and directed to be the licensing authority in Rhode Island for residential and other support programs designed specifically for persons with cognitive disabilities such as brain injury. These licensure requirements shall be the same standards for persons with developmental disabilities except that for these purposes all references to "developmental disabilities" shall mean "cognitive disabilities."

SECTION 4. This act shall take effect upon passage.

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LC01203/SUB A
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APPENDIX D: HOME AND COMMUNITY-BASED WAIVER DESCRIPTION

Waiver Program	Description	Responsible State Agency
Aged and Disabled Waiver	• Services: case management, personal care, environmental modifications, special medical equipment, meals-on-wheels, senior companion and emergency response services. • 1,747 enrollees in SFY 2005	DHS
Physically Disabled Waiver (PARI)	• Individuals with quadriparesis or hemiparesis • Services: case management, personal care, consumer preparation, environmental modifications, special medical equipment, homemaker services and emergency response services. • 88 enrollees in SFY 2005 (being phased out in CY 2006)	Partnership between DHS and local Independent Living Center - PARI
Assisted Living Waiver	• Eligible individuals reside in assisted living facilities • Services: case management, assisted living and special medical equipment. • 288 enrollees in SFY 2005	Collaboration between DHS and DEA
Mentally Retarded Developmentally Disabled Waiver	• Services: case management, specialized homemaker, adult foster care, homemaker, respite, environmental modifications, special medical equipment, residential habilitation, day habilitation and supported employment • 2,780 enrollees in SFY 2005	DHS and MHRH
Community Based Elderly Waiver	• Eligible individuals must be over age 65 • Services: case management, homemaker, assisted living, personal care, meals-on-wheels, environmental modifications, special medical equipment, and senior companion • 690 enrollees in SFY 2005	DEA
Habilitation Waiver	• Services: residential and day habilitation services, private duty nursing, personal care, supported employment, environmental modifications, special medical equipment, personal emergency response units and community-based rehabilitation. • 24 enrollees in SFY 2005	DHS
Personal Choice Waiver	• Individuals with disabilities and elders	DHS

	• Services: participant directed personal care, goods and services, fiscal management, support broker, environmental modifications, special medical equipment, home delivered meals and emergency response • Up to 150 possible participants	Phased in during CY 2006

APPENDIX E: CONNECT CARE PROGRAM OUTCOME MEASURES

INDICATOR	MEASURE	SOURCE	GOAL
PHYSICIAN SATISFACTION	SATISFACTION WITH PROGRAM	ANNUAL SURVEY	>% OF SATISFACTION
CONSUMER SATISFACTION	SATISFACTION WITH PROGRAM	ANNUAL TEL-SURVEY	>% OF SATISFACTION
FUNCTIONAL STATUS	MDS / SF-36 ADLS-IADLS	MDS / SF-36 ANNUAL	SAME OR BETTER FUNCTION
DECREASED ACUTE CARE	ER AND ACUTE ADMISSIONS	CLAIMS ANNUAL	REDUCED ADMISSIONS
FLU/PNEUMONIA IMMUNIZATION	% OF MEMBERS VACCINATED	CLAIMS ANNUAL	ANNUAL FLU >% PNEU
SMOKING CESSATION	% OF MEMBERS WHO QUIT		>% POST 6 MONTHS ENROLLMENT

APPENDIX F: CONNECT CARE PROGRAM CLINICAL OUTCOME MEASURES for Cohort (N=45) at one year in program

INDICATOR	MEASURE	OUTCOME	GOAL
DISEASE EDUCATION	EDUCATION SELF MGT	60%	100% SELF MANAGING
25 MEMBERS WITH DIABETES	HGB A1c GLUCOMETER	16 had one lab test / some more 14 using regularly	100% ANNUAL
8 MEMBERS WITH CHF	AFTERLOAD REDUCTION	8 filled scripts regularly (100%)	>% ON MEDS
22 MEMBERS WITH ASTHMA	INHALED STERIODS	16 filled scripts regularly	>% ON MEDS
35 PSYCH/ DEPRESSION	ANTI-DEPRESSANTS	20 filled scripts more than once	>% ON MEDS AT 6 MONTHS

APPENDIX G: PRIMARY CARE INNOVATIVE GUIDELINES DRAFT

Proposal Draft 1/23/06

Governors' agenda

A health care system with more emphasis on primary care and a balanced deployment of hospital based and specialty care resources

Our goal

Create a stronger primary care system that delivers greater value to RI citizens. We will achieve this goal through changes in policies, benefits, and payment standards that reflect the involvement of all key stakeholders: consumers, payers, providers, and insurers.

We will encourage change and innovation in primary care in two parallel ways:

1. Pilot a "new model" practice

- 21st century model of care, a new practice
- Demonstrates the value – both clinical and economic – of the redesigned primary care practice of the future.
- Serves as a "laboratory" to evaluate various aspects of practice design.
- Created and managed by stakeholders
- Three year time frame

2. Practice innovations

    - Series of stepwise enhancements to office practice, some already in place
    - Supported by changes in health insurance reimbursement, based on the expected value that enhanced primary care will bring.
    - One year time frame

The proposed pilot and practice innovations are listed in the table below, each corresponding to an attribute of a patient-centered primary care practice, as described by Davis and Schoenbaum in "A 2020 Vision of Patient-Centered Care"

tTTable

Attribute (Davis and Schoenbaum, 2020 Vision)	**Pilot innovations**	**Practice innovations**
Superb access	Phone or email booking of all appointments. All types of appointments offered within 24 hours. Timely e-mail and telephone access to practitioner. Fully electronic prescription refills. Fully electronic prescribing. Access to care on nights weekends, holidays. Access to web-based home care decision protocols for simple acute problems.	Office redesign to accomplish: • Shorter wait time to obtain appointments, decrease waiting time in office, decrease phone time “on hold,” etc • Email communication • Weekend office hours • Evening office hours
Patient engagement in care	Easily accessible personal electronic medical/health record, including patient ability to add to record. Automatic prompts for routine preventive care and chronic care treatment. Team focus on health behavior change.	Implement Chronic Care Model. Tracking and/or recall systems for management of chronic disease or provision of preventive services, such as immunizations. Group visits.
Clinical information systems that support high-quality care, practice-based learning, quality improvement	Decision support tools imbedded in office care and medical record. Progress reports on adherence to preventive and	Electronic health record with reporting capacity. Shared use of decision support tools during office visit. Implement Chronic

Attribute (Davis and Schoenbaum, 2020 Vision)	**Pilot innovations**	**Practice innovations**
	chronic care goals.	Care Model.
Care coordination	All test results received quickly and electronically. All specialist consultations. achieved and reported quickly. Post-hospital follow-up begins prior to discharge. Prescription use monitored proactively. Treatment/care plans easily available to patient and other care providers.	Relationships with network of preferred specialists, chosen for high quality and excellent communication. Formal relationship with hospitalist or other in-hospital care provider to facilitate discharge care. Implement Chronic Care Model.
Integrated comprehensive care and smooth information transfer across a fixed or virtual team of providers	Test results and prescription information easily available to patient and other care providers.	Team care. Group visits.
Ongoing, routine patient feedback to a practice	Web-based post-visit surveys.	Patient surveys re: their experience of care.
Publicly available information on practices	Production and dissemination of practice process and outcome data.	Web site with practice information.

APPENDIX H: CERTIFICATION STANDARDS OUTLINE EARLY INTERVENTION SEPTEMBER 2005

APPENDIX I: DHS PROJECT TEAM

Adults in Managed Care Team Members

Kacey Booth
Data Consultant
Strategies and Solutions

Alison Croke
Senior Health Program Development Specialist
Center for Child and Family Health

Deborah Florio
Administrator
Center for Child and Family Health

Kathleen Fresher-Samways
Consultant
Learning Through Assisting
Grantee RI Development Disabilities Council

J. Holly Garvey
Health Program Development Specialist
Division of Health Care Quality, Finance, and Purchasing

Richard Jacobsen, Ph.D.
Project Manager
Center for Child and Family Health

Dianne Kayala
Chief, Family Health Systems
Center for Adult Health

Ellen Mauro
Chief, Family Health Systems
Center for Adult Health

Raymond Maxim, M.D.
Medical Director
Department of Human Services

Renee B. Rulin, M.D.
Consultant
Department of Human Services

Art Schnure
Center for Adult Health
Department of Human Services

Frank Spinelli
Administrator
Center for Adult Health

Sally Strachan
Consultant
Department of Human Services

Monica Sunderman
Data Consultant
Strategic Innovations

Melinda Thomas
Consultant
Center for Child and Family Health

John Young
Associate Director
Division of Health Care Quality, Finance, and Purchasing